Hamilton-Wentworth District Health Council
Conseil régional de santé de Hamilton-Wentworth

Health Promotion Plan Report

SEPTEMBER 1995

Health Promotion Plan Report

SEPTEMBER 1995

A Word About Words

There are many different words and phrases used in the community to describe the same group of people in this report. Some of these are: "less fortunate," "people living in poverty," "people with low incomes," "people who because of their circumstances." Not everyone agreed on the best words to use.

In this report we used the words, "people with low incomes." We are sorry if anyone does not like this phrase or any other words we used in this report. We also apologize to those who do not want to be labelled in any way.

Thanks

Thank you to the many people and organizations that helped to develop the Health Promotion Plan, including...

- all of the people who shared their gifts and struggles during the interviews, focus group meetings and the feedback session
- all of those who organized (or tried to organize) focus group meetings
- the Health Promotion Committee and Health Promotion Plan Advisory Committee members for their guidance and support
- all of the "key informants" who helped to set a focus for the plan
- all of the District Health Council staff for their input and support
- Barry Hallman for helping to gather and analyse local data on poverty
- Jennifer Nicol for changing this report into plain language
- Maggie Fischbuch for all of her help in so many areas of the project
- Jay Wood and Betty McConnell for typing this report

Table of Contents

Members of the Committees

Health Promotion Plan Advisory Committee

Gloria De Santis	Social Planning and Research Council of Hamilton-Wentworth
Kim Farber	Student (resigned May 1995)
Ruth Martin	Welcome Inn Community Centre
Mary Seigner	North Hamilton Community Health Centre
Suzanne Swanton	Non-Profit Tenant Involvement Project
Vicki Woodcox	Department of Public Health Services

Health Promotion Committee

Molly Anderson (Chair)	Victorian Order of Nurses/Retired
Debbie Bang	St. Joseph's Community Health Centre
Kim Farber	Student
Colleen Hesson	Hamilton Psychiatric Hospital (resigned August 1995)
Andy Murie	Big Brother Association of Burlington and Hamilton-Wentworth
Mary Seigner	North Hamilton Community Health Centre
Ann Scott	Department of Regional Social Services
Suzanne Swanton	Non-Profit Tenant Involvement Project
Helen Hale Tomasik	Department of Public Health Services

Staff

Basilia Iatomasi	Health Promotion Planner
Maggie Fischbuch	Senior Health Planner

EXECUTIVE SUMMARY

BACKGROUND

In 1994, the Ministry of Health provided funds for District Health Councils in Ontario to develop health promotion plans. This was done to support one of the province's health goals which is to "shift the emphasis to health promotion and disease prevention." This change in thinking has happened because spending money on medical treatment services has not always improved the overall health of the community.

Health Promotion is defined as:

> the process of enabling individuals and communities to increase control over the factors which protect their health, thereby improving their health. The factors which determine the health of individuals and their communities are both individual and societal, including the social, environmental and economic structures of our communities. Individuals need peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity as a prerequisite to health (Ottawa Charter).

The focus of the Health Promotion Plan is on people with low incomes in Hamilton-Wentworth. This focus was chosen for several reasons. Health and social service agency staff said that poverty is the most significant problem now facing our community. There is also a lot of information which shows that people with low incomes are at great risk for poor health. People with low incomes die sooner and have more frequent periods of sickness and disability for longer periods of time. Finally, the above definition of health promotion naturally leads to a focus on the basic causes of good health and well-being.

GOALS

The goals of the Health Promotion Plan were:

1) to identify a set of health promotion principles
2) to identify the health promotion goals, priorities, strengths and skills of people with low incomes so that this information can be used to plan programs and to help in the review of Healthy Community grants
3) to identify a way to keep health promotion priorities up to date for the grants review process.

HOW WE PREPARED THIS REPORT AND WHAT WE FOUND

1) FINDING OUT ABOUT THE NEEDS OF PEOPLE WITH LOW INCOMES

To find out about the health promotion priorities and needs of people with low incomes, we reviewed 25 community research reports that had been written since 1988. These reports said:

a) that the basic needs of food, clothing and shelter are not being well provided for people with low incomes

b) that there are many gaps in services in areas such as social support, employment, education and leisure and recreation

c) that there are some barriers to services

d) that people do not always know about the services which are available in the community

e) that there is growing frustration with the lack of action from the research that has already been done on poverty.

2) FINDING OUT ABOUT INDIVIDUAL AND COMMUNITY CAPACITIES

The Health Promotion Plan focussed not only on "needs" but also on "capacities". Capacities are the gifts and strengths among people and within the community. Twelve focus groups and some individual interviews were done with people with low incomes to get this information.

We found that:

a) people with low incomes are making many important volunteer contributions to nonprofit organizations, schools, hospitals and sports clubs

b) people with low incomes want to contribute to the community especially if their skills and strengths are nurtured

c) our community has many strengths in its public and community services, in its people and in its green spaces and environment

d) learning skills, having resources and having the ability to makes decisions are important to promoting empowerment

e) both self-help and organizations which use and support people's strengths are empowering. People also want a sense of community, belonging and "family" and any group which provides this is empowering.

HEALTH PROMOTION PRIORITIES

There were many ideas about ways to improve the health promotion funding process and the types of projects which get funding. These suggestions were:

- projects should try out,in different and new ways,to address basic needs
- projects should assist in building social support and developing communities
- projects should develop self-help or peer based groups
- projects should develop practical skills and increase knowledge
- projects should prevent the growth of poverty or the harmful effects of poverty
- projects should help people get access to information about community resources
- projects should build on the assets and contributions of people with low incomes.

GUIDELINES OR PRINCIPLES FOR HEALTH PROMOTION

These health promotion principles come from discussions we had with people with low incomes and from articles and books we read.

Health Promotion

- empowers both individuals and communities
- supports the availability of choices and people making choices
- recognizes that the basic needs of food, clothing and shelter are priorities
- aims to distribute power and resources fairly for the well-being of all
- focuses on the well-being of the population as a whole
- uses many strategies like education, skill development, and advocacy at the individual, group and community level
- includes the whole person - the physical, spiritual, psychological, emotional and social aspects
- respects the diversity of all people
- respects the uniqueness of all people
- is a life long process including all people in any state of physical or mental health
- is directed by the people, groups and communities involved
- encourages everyone to be responsible for good health
- encourages people and groups to work together
- values volunteering
- builds communities
- prevents problems from developing that can harm people and communities

RECOMMENDATIONS

1.0 Education and Advocacy

Poverty and its effects on health and well-being are serious problems in Hamilton-Wentworth. Because of this, we recommend:

1. that the Hamilton-Wentworth District Health Council take on an educational and advocacy role to respond to the problem of poverty by using the following approaches:

    a) that Council educate new members about health promotion, population-based health planning and the current health status of people with low incomes in Hamilton-Wentworth; also that Council participate in ongoing education in these areas

    b) that the Health Promotion Committee gather information with other community partners and give Council a yearly update on the health status of those with low incomes in Hamilton-Wentworth; also that this yearly health status report be published and distributed in the larger community and to key people and organizations

    c) that the Hamilton-Wentworth District Health Council begin to develop partnerships with other organizations including other planning groups to respond to poverty in a coordinated way

    d) that the Hamilton-Wentworth District Health Council encourage the Ministry of Health to recognize the importance of health promotion, and that the Hamilton-Wentworth District Health Council encourage the Ministry of Health to provide sufficient funding for the Healthy Community Grants Program.

2.0 Healthy Community Funding

With regard to the Healthy Community grants funding, it is recommended:

2.1 that the Hamilton-Wentworth District Health Council make poverty a long term priority for Healthy Community funding.

2.2. that the Health Promotion Committee give priority to proposals that:
- try out in new and original ways, projects that address people's basic needs
- encourage social support and the development of communities
- develop self-help and peer support projects
- develop practical skills and increase knowledge
- prevent the growth of poverty and the harmful effects of poverty
- make it easier to get information about community resources
- recognize and build on the assets and contributions of people with low incomes

2.3 that the Health Promotion Committee support "grassroots groups" in the Healthy Community Grants process by:

- working toward setting aside at least half of the Healthy Community funding for grassroots groups
- organizing a yearly grant writing workshop for grassroots groups
- identifying community resources to help grassroots groups in writing grant applications
- inviting groups that have received funding to an annual community meeting to discuss and evaluate the results of their projects
- starting discussions with local funders about ways to support the ongoing development of grassroots groups which receive funding

2.4 that the Health Promotion Committee let grassroots groups and health and social service organizations know which proposals have been funded.

2.5 that the Health Promotion Committee, in its role of monitoring Healthy Community Grants, develop ways to evaluate the results of individual and community capacity building projects

2.6 that the Health Promotion Committee set up a reference group of "grassroots people" to advise on health promotion priorities, the grants review process and ways to consult with people in the community

3.0 Updating the Health Promotion Plan

To keep the Health Promotion Plan up to date it is recommended:

3.1 that the Health Promotion Committee update the Plan every two years by reviewing new research and reports, interviewing key informants, and consulting with "grassroots people"

3.2 that the updates of the Health Promotion Plan report both community needs and capacities.

4.0 Implementation Strategies

To share the information from this report and to start to work on the issues that were raised in the Plan, it is recommended:

4.1 that the Hamilton-Wentworth District Health Council send this report and its recommendations to local health and social service organizations, churches, school boards, grassroots groups, local funders, planning bodies, the Ministry of Health and other relevant provincial ministries and local members of provincial parliament.

4.2 that the Hamilton-Wentworth District Health Council meet with local members of provincial parliament and regional politicians to talk about poverty and its impact on the population and policies that will respond to these issues.

4.3 that the Health Promotion Plan, and the principles of health promotion, be sent to all committees and task forces of the Hamilton-Wentworth District Health Council for use in their planning processes.

INTRODUCTION

In 1994 the Ministry of Health provided funds for District Health Councils in Ontario to develop health promotion plans. This is to support one of the province's health goals which is "to shift the emphasis to health promotion and disease prevention." This change in thinking has happened because spending money on medical treatment services has not always improved the overall health of the community.[1]

In October 1994, the Hamilton-Wentworth District Health Council began developing its own health promotion plan. The Plan concentrates on people with low incomes in Hamilton-Wentworth because they are at great risk for poor health and well-being.

The goals of the Plan are:

1. to identify a set of health promotion principles,
2. to identify the health promotion goals, priorities (what is most important) and capacities of people with low incomes. This information can then be used to plan programs and to help with the review of the Healthy Community grants which the Health Promotion Committee manages.
3. to identify ways to keep health promotion priorities up to date for the grants review process.

DEFINITIONS/FRAMEWORKS

This Health Promotion Plan focuses on people with low incomes. It looks at what people with low incomes need. It also focuses on the skills and abilities that people have. The definitions and frameworks that were used for the Plan are explained below.

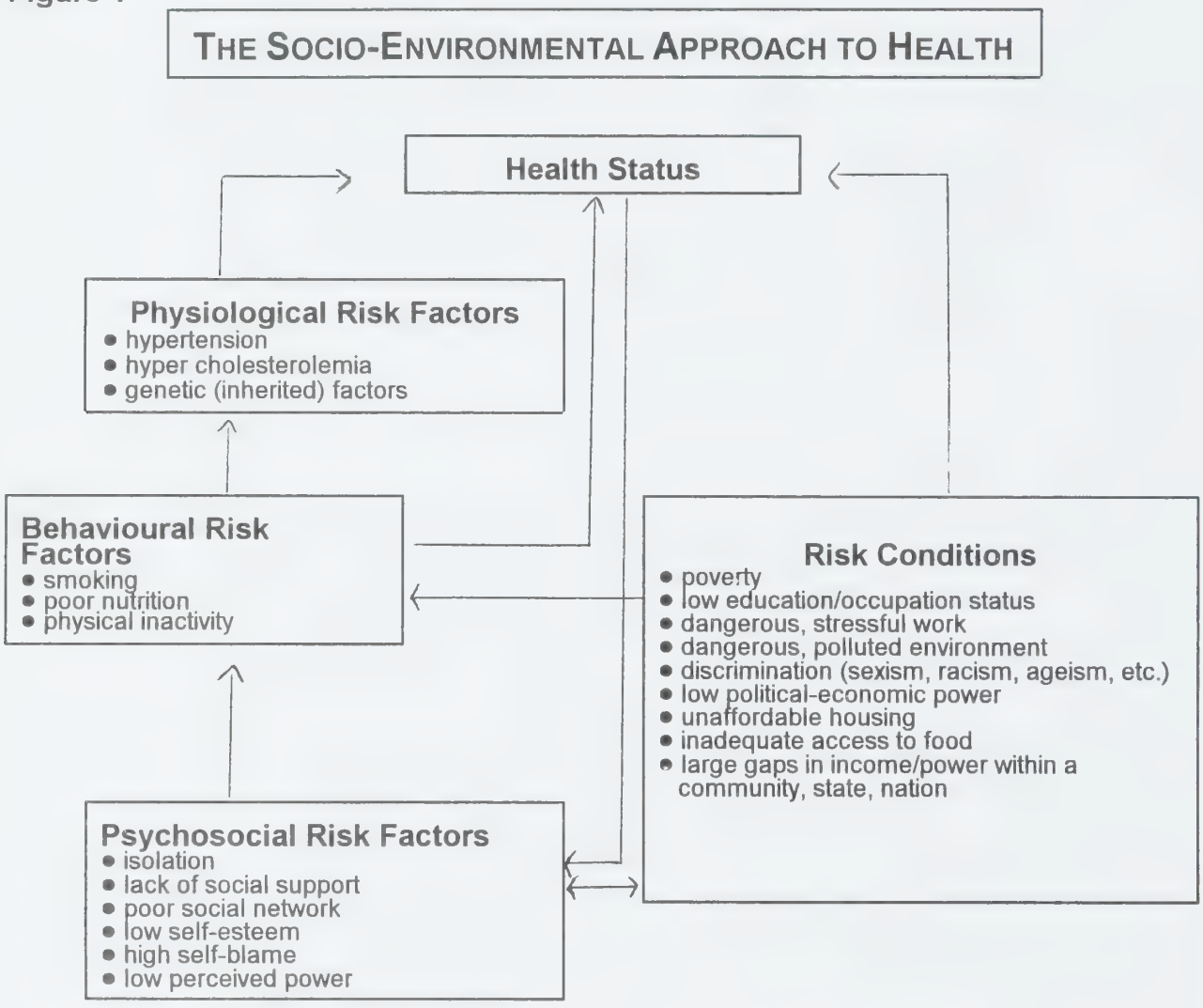
The Plan uses the Ottawa Charter definition of health promotion which says that:

> *Health promotion is the process of enabling individuals and communities to increase control over the factors which protect their health, thereby improving their health. The factors which determine the health of individuals and their communities are both individual and societal, including the social, environmental and economic structures of our communities. Individuals need peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity as a prerequisite to health.*[2]

This definition means that health and well-being are created by many things. It says that some risk conditions, such as poverty, unemployment, lack of housing, and pollution, harm peoples' health. Health is not just about finding the right medical cure. It is not just about behaving in the right way like exercising or not smoking. It is about fairness and having rights.

Ron Labonté, who is a health promotion consultant, has shaped these ideas into a "socio-environmental approach to health"[3]. In the diagram below, the effects of certain conditions, such as poverty, are shown. A person's behaviour (the way he or she acts), physiology (health of his or her body), social support, emotional well-being and overall health can be affected by poverty.

Figure 1



Labonté contrasts this socio-environmental approach with the medical and behavioural approaches to health [4].

Figure 2

Summary of the Different Approaches to Health			
	Medical Approach	**Behavioural Approach**	**Socio-Environmental Approach**
Health Concept	- biomedical; absence of disease or disability	- individualized; physical-functional ability, physical well-being	- positive state; connectedness to one's family/friends/ community; self-efficacy; ability to do things that are important or have meaning; psychological and social well-being
Health Determinant	- disease categories, physiological risk factors (eg. hypertension)	- behavioural risk factors (eg. unsafe sex)	- psychosocial risk factors (eg. isolation), and - socio-environmental risk conditions, (eg. poverty)
Target	- high risk individuals	- high risk groups (those with unhealthy lifestyles) - children (promotion of healthy lifestyles)	- high risk environments
Principle Strategies	- surgery, drugs, therapy - illness care - medically managed behaviour change (diet, exercise, patient education and compliance) - screening for risk factors	- health education - social marketing - advocacy for healthy public policies, supporting lifestyle choices (eg. work-place smoking bans)	- personal empowerment - small group development - community organization - coalition advocacy - political action
Program Develop-ment	- professionally managed	- negotiated with individuals, communities and professionals (ie community programming)	- managed by community in critical dialogue with supporting professionals and agencies (ie. community development programming)
Prevention Level	- tertiary prevention (disease intervention)	- secondary prevention (improving lifestyles) - primary prevention (creating healthy lifestyles)	- primary prevention (creating health lifestyles) - health promotion (creating healthy living conditions)
Success Criteria (examples)	- decrease in diagnosed morbidity - decrease in specific age-standardized mortalities - decrease in prevalence of physiological risk factors	- improved existing lifestyles - healthier lifestyles 'early in the life-cycle' - enactments of healthy public policies (eg. smoking bans)	- improved personal perception of health, improved social networks, quality of social support - improved community actions to create more equitable social distribution of power/resources and sustainable economic practices

Figure 3

LEADING HEALTH PROBLEMS BY THE THREE APPROACHES [5]		
health problems tend to be 'named' differently by each of the three approaches:		
Medical Approach	**Behavioural Approach**	**Socio-environmental Approach**
cardiovascular diseases cancer AIDS diabetes obesity mental disease hypertension etc.	smoking poor eating habits lack of fitness drug abuse alcohol abuse poor stress coping lack of lifeskills etc.	unemployment powerlessness isolation pollution stressors hazardous living and hazardous working conditions etc.

By looking at the three approaches, it is clear that the reasons for health problems and the ways to fix health problems are understood in different ways. In the socio-environmental approach, Labonté identifies five ways to try to fix risk conditions such as poverty [5].

Figure 4

One way to fix problems like poverty is through organizing the community. The community organization and development circle is shown above.

In this community development circle is a model that was developed by Kretzman and McKnight. It is called "asset-based community development". This model looks at the skills, strengths and capacities of people with low incomes. It also looks at the skills, strengths and capacities of communities to promote change, health and well-being. This model states that finding local solutions to problems and forming relationships among people through associations or groups of people are the ways to build strong communities. This model is different than how problems have been thought about in the past. Usually researchers and community workers have focussed on "needs". These are the things that are missing and the problems that exist among people and communities. The two different ways at looking at problems faced by people with low incomes are compared in these two maps.[6]

Figure 5 **NEIGHBOURHOOD NEEDS MAP**

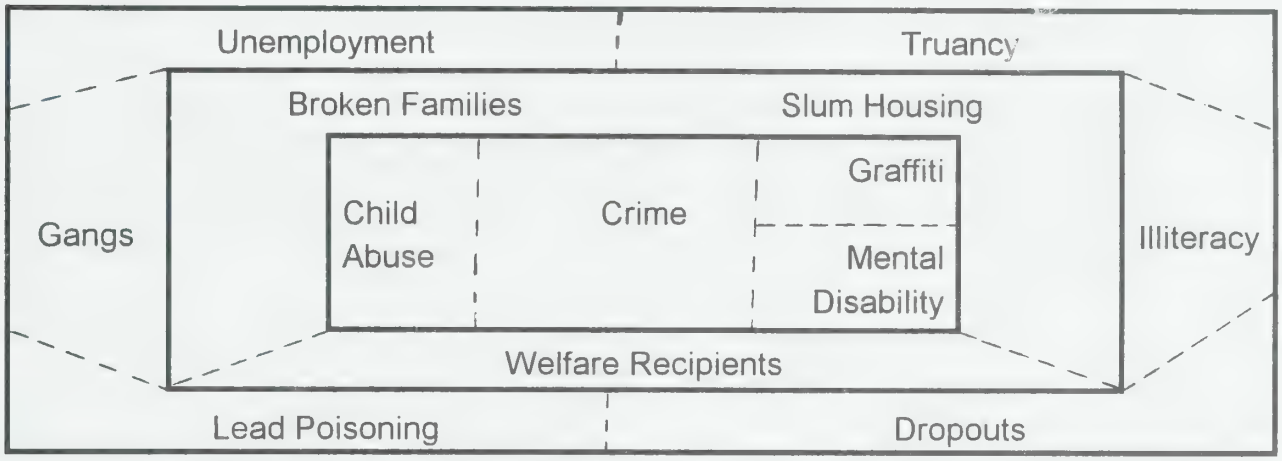
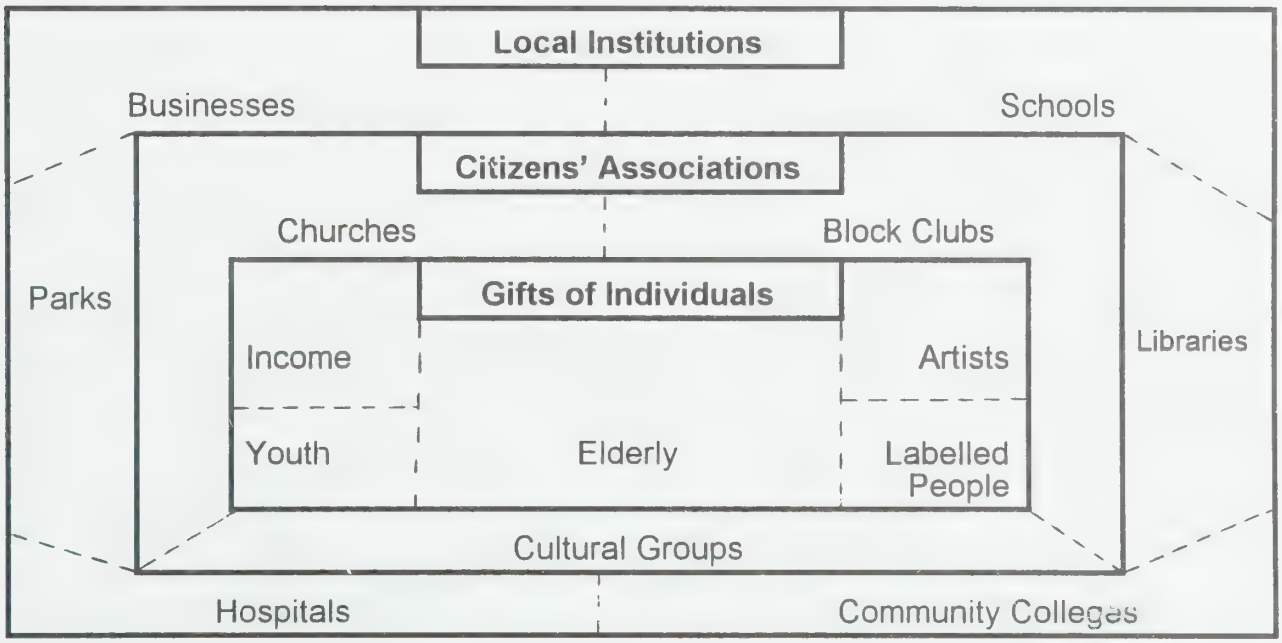


Figure 6 **COMMUNITY ASSETS MAP**



These two diagrams show that people can be seen to have gifts and skills. People can also be seen to have needs and problems. It depends on how you look at them. This Plan supports the view that people with low incomes have the gifts and capacities to promote their health and well-being.

POVERTY AND HOW IT AFFECTS HEALTH AND WELL-BEING

Poverty can be defined in many ways. Some people may not think they are poor yet their incomes may fall within poverty line measurements. The opposite can also be true. Some people think they are poor but their incomes are actually above poverty line measurements.*

In this Plan, the Health Promotion Committee defines poverty in this way:

> Poverty is about inequality, lack of control and deprivation. People who are poor are deprived of access to basic human needs such as shelter, clothing, safety and nutritious and adequate amounts of food. They are also deprived of many opportunities - to live their lives as they wish, to fully participate in society, to develop good social supports, to achieve their full human potential and to sustain healthy concepts of self-worth and dignity.

The harmful effects of poverty are clear. In a report for the Ontario Social Assistance Review Committee, the information shows that people with low incomes die earlier, have more illnesses more often, have fewer years of life that are disability free and are less happy.[7] These findings have been shown in other studies.[8, 9, 10, 11]

---

*Poverty lines are one way to measure poverty. One poverty line measurement comes from Statistics Canada and is called Low Income Cutoffs (LICO's). This poverty line is based on different family sizes and reflects differences in the costs of food, clothing and housing in different sizes of communities. In 1994, low income cut offs for a community the size of Hamilton-Wentworth were:

Number of People in the Family	Maximum Income
1	13,596.00
2	18,430.00
3	23,426.00
4	26,969.00
5	29,467.00
6	31,983.00
7+	34,403.00

Information about the effects of poverty on children show that:

- the number of infants and babies who die is about twice as high in poor neighbourhoods as in rich neighbourhoods

- the low birth weight rate is 1.4 times higher in poor neighbourhoods than in rich neighbourhoods

- poor children are more likely to die from injuries than non-poor children

- poor children are more likely to have lasting health problems and to be admitted to hospital than non-poor children

- poor children are more likely to have problems at school and psychiatric problems than non-poor children

- poor children are less likely to feel good about themselves than non-poor children 12*[12]

The Ontario Health Survey (OHS) data also gives us some useful information. In the OHS study people were asked to report their feelings about their health. This is called self-reporting. Self-reporting is shown to predict the rates of death, disease and the use of health services.

The survey showed that self-reported rates of well-being decrease with poverty and there is higher use of some health care services by those with low incomes. Forty three percent (43%) of very poor Ontarians reported very good or excellent health, compared to 51% of the poor, 58% of those with lower middle incomes, 62% of upper income earners and 69% of the wealthy. Similarly, 45% of people on social assistance said their health was excellent compared to wage or salaried income earners (64%). Fifty eight (58%) of those who are very poor reported more than one actual health problem compared to 35% of those who are wealthy. [13]**

It is not surprising therefore, that people in the OHS study who are poor use some health care services more than those who are rich. Forty-two percent (42%) of the very poor saw a general practitioner (doctor) or a specialist 5 or more times in the year before the survey was done but only 20% of the rich saw a doctor or specialist that many times. The rates for using health services are the same for those who actually have health problems, but it should be said again that people with low incomes are more likely to have health problems.[14] Other research also shows that people with lower incomes have higher rates of hospitalization, longer hospital stays, and use hospital emergency room care more than those who are wealthier.[15]

---

* this report measures poverty using the Statistics Canada low income cut offs.

**this study designed a scale based to approximate low income cut offs used by Statistics Canada. For a household of four people, for example, the following cut offs were used:

very poor = $11,199
poor = $12,000 - 19,999
lower middle = $20,000 - 39,399
upper middle = $40,000 - 79,999
wealthy = $80,000 +

The OHS data also show that poverty is more important than activities like smoking and exercising on self-reported health status. People with low incomes who smoke and rarely exercise, say they are less healthy than people who are rich and smoke and rarely exercise. [16]

Other research shows that people who are poor are more likely to be affected by some diseases than the wealthy. If the diseases that tend to affect people with low incomes were eliminated, "the socio-economic differential would express itself through some other diseases. It suggests some overall greater vulnerability to a variety of specific ailments among poorer as opposed to wealthier people.[17]"

Finally, how money is distributed among people in a country also affects health. For example, in some countries where there is a smaller gap between the rich and the poor, people tend to live longer.[18] Although Canadians live longer than people in many other countries, the following has occurred in terms of how income is spread among people in Canada: "The polarization between rich and poor families is extreme for all years - the poorest 20% receive approximately 6% of total family income, while the richest 20% receive almost 40% of total income. The distribution of total family incomes in Canada has become more unequal between 1980 and 1990.[19]"

This research is very important because it shows that poverty has severe impacts on peoples' health. Poverty costs communities a lot of money because more people with low incomes use more health services. Poverty costs society in other ways because there is also a loss of dignity and the waste of a person's potential.

THE EXTENT OF POVERTY IN HAMILTON-WENTWORTH

This information describes how much poverty exists in Hamilton-Wentworth.

In 1991*

- 15.1% of the population of Hamilton-Wentworth had incomes below the Statistics Canada low income cut offs (68,201 people)

- 19.6% of children under 6 years of age and 16.5% of children aged 6-14 years lived in poverty (a total of 15, 442 children)

- 17.7% of youth between 18-24 years of age lived in poverty (5,128 youth)

- 17.3% of senior citizens aged 65-69 and 27.6% of senior citizens over 70 years of age lived in poverty (14,465 senior citizens)

- 14.7% (18,295) of families lived in poverty

- 31.9% of single males and 44.1% of single females lived in poverty

---

* This data is for Hamilton-Wentworth. It is taken from the Census of Canada, Income Statistics for the Hamilton Census Metropolitan Area. The numbers shown are the latest available.

In 1991

- 62.1% of the 46,200 people with disabilities in Hamilton-Wentworth lived in poverty[20]

In 1994

The following numbers of people were fed through food banks:

- Wesley Urban Ministries fed 35,353 people through lunches and 25,163 people through the no charge food store[21]
- Neighbour to Neighbour provided food to 9,887 households[22]
- the Good Shephard Centre distributed 149,979 hot meals, bag lunches, or emergency food parcels[23]
- the Salvation Army provided food for 7,541 children and 11,415 adults; in addition to this, at Christmas they provided food for 1743 families, 2999 adults and 2,954 children[24]
- Mission Services fed over 5200 families and 12,240 individuals[25]

In 1994

- the average unemployment rate in the Hamilton Census Metropolitan area was 8.3%[26]

In June 1995

- the General Welfare Assistance caseload was 15,718 which represented 26,701 beneficiaries[27]

- the Family Benefits caseload was 20,215 which represented 44,925 beneficiaries[28]

In 1995

- one study estimated that the number of people who are homeless in Hamilton-Wentworth on any given day is 160 people. This was found out through identifying those who use emergency housing and health services or lived on the street.[29*]

The definitions of homelessness and therefore the number of people who are homeless varies. Some definitions include people who do not want to, but are forced to live with others. If we use this definition then the number of people who are homeless would increase. See the Housing Help Centre report called "Homelessness in Hamilton-Wentworth", written in 1992 for a discussion on the definitions of homelessness that can be used.

Hamilton-Wentworth also has above average levels of poverty among some groups of people compared to some other regional municipalities in the province. For example, Hamilton-Wentworth had the second highest level of poverty among families.

Table 7[30]
Proportion of families with incomes below the Statistics Canada Low Income Cut-off's.

MUNICIPALITY	INDEX
Halton	5.3
York	6.3
Haldimand-Norfolk	7.2
Durham	7.3
Waterloo	9.6
Niagara	10.5
Ottawa-Carleton	10.9
Sudbury	11.7
Hamilton-Wentworth	**14.8**
Toronto	16.3

(This information comes from the 1991 Census.)

Hamilton-Wentworth had the highest levels of unattached (single) individuals living below the low income cut-offs.[31]

Table 8

Percent of Unattached Individuals below the Low Income Cut-offs.

MUNICIPALITY	INDEX
Hamilton-Wentworth	**41.3**
Sudbury	35.9
Toronto	33.5
Niagara	33.3
Ottawa-Carleton	32.0
York	30.2
Waterloo	29.1
Durham	27.1
Halton	26.6
Haldimand-Norfolk	23.4

(This information comes from the 1991 Census.)

Hamilton-Wentworth also had the highest number of children who live in poverty with their single parents.

Table 9[32]

Percentage of Children (0-19 years of age) who live in Low Income Lone Parent Families, 1986.

MUNICIPALITY	INDEX
York	1.89
Halton	3.02
Durham	3.96
Haldimand-Norfolk	4.07
Ottawa-Carleton	5.95
Waterloo	6.17
Niagara	7.72
Sudbury	8.13
Toronto	8.54
Hamilton-Wentworth	**9.02**

(This information comes from the Ministry of Community & Social Services Database.)

The Ontario Health Survey also asked people about their feelings of well-being and happiness. In one question, people were asked to say how often they felt different emotions over the last year.

There was often a difference between those with low incomes and those with incomes greater than $50,000.00 in the answers they gave to this question. For example, people with low incomes reported feeling more tired, tense and bored, and were more worried about their health. The largest differences in people's answers are found below.

Table 10

OHS RESPONDENTS WHO SAID THAT THEY "HARDLY EVER FELT"

	quite lonely	felt rather low	worried about my health	felt quite loved and appreciated
Low income	56.9%	46.9%	51.9%	13.5%
Income less than $50,000	72.6%	60.7%	59.3%	6.8%
Income more than $50,000	76.9%	66.0%	70.3%	4.2%

(This information comes from the Ontario Health Survey Data, 1990.)

The answers to this question show that people with low incomes felt lonelier, more "low," less loved and appreciated, and were more worried about their health than people with higher incomes.

Overall, the data show that poverty is a serious problem in Hamilton-Wentworth. This is true if you look just at Hamilton-Wentworth alone or if you compare our community to other regions. Poverty touches the lives of people of all ages and affects how people feel their about health and well-being.

THE PROCESS - (How we created this report)

THE HEALTH PROMOTION PLAN ADVISORY COMMITTEE

At the start of the project, the Health Promotion Committee provided the Hamilton-Wentworth District Health Council with the principles, or guidelines, that would be followed to the prepare the Plan. These principles are listed in Appendix A on Page 43. When the focus of the Plan became poverty and people with low incomes, a Health Promotion Plan Advisory Committee was formed. The purpose of the Advisory Committee was to give advice on preparing the Plan. The members of the committee included people who know about poverty and have research skills. It also included people knowledgeable about health promotion.

DATA COLLECTION - (How we gathered the information for the Plan)

We gathered information for the Plan in three ways:

1. We did two sets of interviews with knowledgeable people in the community. These people are called key informants.
2. We reviewed community reports that had already been written.
3. We met with small groups of people which are called focus groups. The people involved in the focus groups live in Hamilton-Wentworth and have low incomes. We also interviewed some of these people individually.

KEY INFORMANT INTERVIEWS

There were two sets of people interviewed. At the beginning, 22 people from different health and social service groups in the community were interviewed. A list of these people is found in Appendix B on Page 46. These people came from different areas and had different jobs. Some people were social and urban planners. Some were staff who work directly with the public, such as staff in community health centres. Others were community development workers. Some people were administrators, managers, or researchers. Other people worked for organizations that give money to programs.

These interviews were done to find out what people thought were the most important issues in health promotion and what kind of general guidelines, or principles, are important when doing health promotion work. We also wanted to find out what health promotion projects were working well in Hamilton-Wentworth.

The following health promotion priorities were identified during the interviews. The priorities at the top of this list were mentioned most often:

- poverty (including child poverty)
- empowerment. (Those who were interviewed described empowerment in different ways. For some, empowerment means allowing and encouraging people to do things for themselves. Others said that empowerment includes people taking part in what is happening in their community. It also includes people developing their skills and building community capacities, or strengths.)
- issues facing groups from different cultures.
- issues facing groups that are vulnerable. This could include people who have used or are using mental health services, seniors, and isolated single men.
- unemployment
- injury prevention
- developing skills (Agency staff said there is a need for parenting and hygiene courses.)

Poverty was named as a very important health promotion priority by 17 of the 22 people interviewed. Empowerment was also mentioned often. People said that health promotion can only work if people and communities have their own power to make things happen. Some people said that developing skills and letting people take part in projects would support empowerment.

The interviews with key informants were very helpful because they helped to focus the Plan. The focus became poverty and the ways people and the community can be empowered to build on their strengths and skills.

With this focus in mind, six more people were then interviewed. These people are listed in Appendix C on Page 47. They were managers, staff who worked directly with people who use health and social services, volunteers from food banks, and staff who work in agencies which serve people with low incomes. These interviews were meant to identify those who live in poverty in the community. Another reason they were done was to find out about successful health promotion projects for people with low incomes. We also wanted to find out what the people who provide services think are the needs of people with low incomes.

These six agency people said that the most important needs of people with low incomes are greater access to nutritious food, greater social support and greater access to health and dental services. These key informants also said that because of the changes in the economy, poverty now affects people of all ages in Hamilton-Wentworth.

REVIEW OF COMMUNITY REPORTS ON POVERTY

We then reviewed twenty-five community reports. We did this to gather information that had already been collected on the needs, priorities and issues facing people with low incomes. (Appendix D , found on pages 48-74 contains a short version of each report).

The reports included:

1. priority setting documents (which say what things are most important)
2. needs assessment reports (which look at the needs of people)
3. program evaluations (which measure the effectiveness of programs in the community)

We looked at reports which were written over the last eight years. Many were about specific groups, such as people with physical disabilities. Other reports, such as the Chairman's Task Force on Sustainable Development, were about the whole population of Hamilton-Wentworth. The themes in these reports are found in the section called "Needs".

FOCUS GROUPS AND INTERVIEWS WITH PEOPLE WITH LOW INCOMES

Focus groups and interviews were done in the next part of the project. The purpose was to find out about the strengths and skills of people with low incomes and of the community. The questions we asked were first tested with four people with low incomes. We changed some the questions to make them clearer. The questions used are listed in the section called "Capacities."

Focus groups were set up through individuals and groups that work with people with low incomes. The focus groups were usually held at regularly scheduled meetings of the groups that were involved. Some focus groups were held at specially arranged times. Since some people could not come to the focus groups, individual interviews were also done.

These were the focus groups and interviews that were held during May, June and July, 1995.

NAME OF GROUP	NUMBER OF PEOPLE
Welcome Inn Seniors Group	21
Welcome Inn Women's Group	12
Heart of the City Action Centre Committee	6
THIAC (Tenant and Homeless Information Action Centre)	8
Hamilton-Wentworth STAR (Skills Through Activity and Recreation)	8
Hamilton Housing Authority Tenant's Council	3
Baby's Best Start Group	5
Francophone Persons Focus Group	2
A Focus Group with Immigrant Women	7
United Disabled Consumers	7
Mental Health Rights Coalition	7
Emmaus Place Residents	10
Individual Interviews	5
TOTAL	101

At the beginning of doing the focus groups, people were asked to fill out a form. This form was used to gather information about age, education, income, etc.. Some people did not like filling out the form. Some people only filled out part of the form. Sometimes there was not enough time to fill them out. For these reasons we decided to stop using the form.

However, people at the focus groups often told us some information about themselves such as how old they were, who they live with, and where they got their income. The staff person who led the focus groups also got some information from the social service agency staff who had set up the meetings, and some of the information was obvious, such as sex.

Seventy (70) women and thirty-one (31) men took part. The youngest person was 12 years old and the oldest was in their 80's. There were single parents, single men and women, people with physical disabilities, aboriginal people, working couples with low incomes, consumers/ survivors of mental health services, Francophones and women from different cultural backgrounds. Most of the people received some kind of government assistance like Canada Pension Plan disability or General Welfare Assistance. Some people worked for low pay. Some people were not poor but came because they were interested in health promotion.

We should mention that we did not talk with people who were not already involved with some kind of structured program, service or advocacy group. We used these types of groups to get in touch with people. Three attempts were made to meet with people who were not involved with any group or service. Leaflets were given out at one large non-profit housing apartment building and two downtown residences where low income single people tend to live. No one came to the meetings that we advertised.

FEEDBACK SESSION

All of the people who took part in the focus groups or interviews were invited to a "feedback session." This was organized to share the information from all of the focus groups and interviews. At the meeting, people were asked what they thought of the information that had been gathered and to suggest changes especially to the recommendations. Four people came to this feedback session. They agreed with how the information from the consultation had been summarized. They also added further information and explanation.

WHAT WE FOUND OUT

WHAT PEOPLE WITH LOW INCOMES NEED

At the beginning of the project 25 community reports that were done between 1988 to 1995 were reviewed.

The reports showed that the needs of people with low incomes have been very well reported. The needs that were mentioned in the reports are both general and specific. Needs can be specific because different groups of people face different experiences and barriers. In a report about street youth for instance, new services such as "safe houses" were recommended. For people with physical disabilities, better coordination of existing services was identified. Help with the immigration process was needed by people who were immigrants.

General needs or themes were also obvious when the reports were looked at as a whole. The needs and themes listed below are based on what people with low incomes said in these reports.

a) Basic needs, such as having enough food, shelter and clothing, are not well covered for many people with low incomes in Hamilton-Wentworth. Many reports showed that there were long waiting lists for subsidized housing. The reports also showed a need for more adequate incomes.

b) There are many common gaps in the social service network. Some reports said that there should be more chances for people to get social support, jobs, formal and informal education and leisure and recreational activities. Other common needs were better transportation, advocacy services and a safer community.

c) Several reports listed some barriers to services. Some people have a hard time using services if the hours of operation are limited or if agency staff only speak English. Another important barrier was that some people with low incomes face discrimination or are treated insensitively.

d) Almost all of the reports showed that people with low incomes are not well aware of community services. People said they do not know where to find out about services.

e) Some reports showed that people were frustrated because nothing was done after the projects and reports on poverty were over. People did not think their lives had changed after all the research was done. These people felt that more research is a waste if it does not make a change.

CAPACITIES OF PEOPLE WITH LOW INCOMES

Our research looked at "capacities." Capacities are the strengths, assets, and gifts of people or of the community. We looked at capacities for a number of reasons. The needs of people with low incomes have already been reported. The capacities of people have not been the focus of any reports. Also, there is little health promotion grant money available in Hamilton-Wentworth; $75,000 a year in 1995. This is not enough money to meet all of the needs of people with low incomes. Instead this money can best be spent by supporting projects that use the strengths of people and groups in the community. As was said before, the model used in this Plan says that well-being can be created by informal groups and associations which build the community. This Plan was meant to find out about these groups and community resources. Looking at capacities is also important as communities have less government money to use to address needs and problems.

Specific questions were used in the focus groups and individual interviews. Some questions were used to find about the skills and gifts of people with low incomes and the strengths in the community. There were also questions about empowerment. One question asked what organizations can do to better help people with low incomes.

These were the questions asked:

a. Everyone is good at something. What are you good at and what do you like to do?
b. What groups/clubs have you belonged to?
c. What did you like about being involved in these groups/clubs?
d. What makes you feel most in control of your life?
e. If you could design the perfect club, group, organization, (where you can go and meet people, hang out, get help and help others), what would it be like?
f. What do you like most about Hamilton-Wentworth and where you live?
g. What types of projects should be funded through the health promotion grants?

In two focus groups the meetings were tape recorded and the information was later written down. In the other groups and interviews, the person who led the meetings took notes. In the rest of the report, when we quote what people said at the focus groups and interviews, we have typed them in *italics*. The quotes can best show the thoughts and feelings of the people in the focus groups.

INDIVIDUAL STRENGTHS AND CAPACITIES

People had different reactions when they were asked about their skills and strengths. Some people were not sure how to answer and other people answered confidently and quickly. Some people were from cultures that do not encourage people to talk about their personal strengths. They had trouble answering these questions. Sadly, many people said they do not have any skills or strengths.

The range of skills among the people in the focus groups was impressive. People had important personal skills such as being patient, being able to motivate and work well with others, being curious, being able to see the strengths in others and being willing to be challenged and to learn. Many had good interpersonal skills and enjoyed being with other people. Some said they were good parents and caregivers. Others had artistic skills such as flower arranging, singing, crocheting, needlepoint, painting and poetry writing. Two people have published their poetry. Many enjoy housekeeping, cooking and gardening. Others said they had computer, writing, public speaking, telephone and organizing skills. People also had skills they had learned in their jobs. Some used to be carpenters, chefs, labourers, occupational therapists and registered nurses assistants. Some of the people from different cultures were very well trained and educated, but they had trouble finding work in their field. This group included teachers, economists, and a social worker.

Some people said that all people have gifts and strengths.

> *"I think we all have hidden talents that we don't really know about, but sometimes, something, will bring them out ... someone comes along and says "oh, that's good".*

We all have gifts, we need to contemplate what they are ... if you hold your gifts in you will explode.

I believe everyone has something to contribute."

At the end of one focus group, a woman said that she sat back and listened with surprise and delight at all of the skills and talents among people in the focus group. She felt that they must find a way to better use these skills.

COMMUNITY AND VOLUNTARY INVOLVEMENTS

Important and meaningful contributions to the community have been and are still being made by the people that took part in this project. Many groups, such as churches, non profit organizations, sports groups, schools and hospitals benefit from their energy, skills and volunteer work. Some of the volunteer work done by people with low incomes includes involvement in the groups below:

- churches
- the Voluntary Action Centre
- Boy Scouts
- The Literacy Council
- Hamilton Psychiatric Hospital
- The Red Cross
- Pen Pal Ministries
- Multiple Sclerosis Society
- Extend-a-Care
- Disabled Aged Regional Transportation System
- teaching English as a Second Language at the library
- hospitals (candy strippers, hospital visitors)
- Regional Advisory Committee for the Physically Disabled
- the Seniors Activation Maintenance Program (a 12 year old volunteers here)
- coop nursery schools
- Pioneer Girls
- Home & School Associations
- Cooperative Housing Sector
- The Women's Centre
- Mennonite Central Committee
- The Terry Fox Run
- Tele-Touch
- Friends of Schizophrenics
- sports clubs
- teaching first aid
- helping with political campaigns
- helping a wheelchair bound senior citizen

One person has volunteered with 13 groups, and another with 27 groups. This is a very important gift to our community.

One person said that "you can't put a price on what volunteers do." This means that the work of volunteers is just as valuable and important as paid work.

There are many reasons why people volunteer in the community. Most often, people volunteer because it gives them personal satisfaction and adds purpose and meaning to their lives. They feel that they can help improve the community and help others.

In their own words, people said:

I know I can make a difference with my neighbours and in my neighbourhood.

You feel good when you help somebody who is lonely and depressed.

You feel involved and you contribute; you have an opportunity to change the world around you and share your experiences; you learn to assert yourself

Volunteering keeps me alive. I get satisfaction knowing that I've helped somebody...it keeps me on the go.

I'm good at working in the kitchen with the kids or working with the seniors; I enjoy it; I feel good about myself after what I did for the people the next day; like this morning I went out serving breakfast for the kids and I feel good about it because I'm doing something for them, not just myself...when I see them feel happy and good, I feel happy and good about myself.

Being involved gives us a context to our lives - you're doing something

I saw so many people who were worse off than me and I was able to help them.

Others felt that they want to do something for the community in return for receiving some form of government assistance.

My community helps me and I want to say thanks to the community and let them know I'm responsible.

Some people believe that volunteering is an important part of living in a community.

I was taught that you have to do everything you can for your family and your family is not just the people that live in the four walls with you...it's the community you live in

Others said that volunteering is fun. It also gives them a chance to learn important skills and to meet other people.

The question about community and volunteer involvements usually led to interesting comments from people who are on a disability pension through the Canada Pension Plan. Until April 1995, people receiving disability pensions could not do volunteer work. Now they can. All the people in the focus groups agreed that this change in policy was very important. People want to do something for the community. They feel this helps them keep their mental and physical health. One person said:

the government does doubletalk...they don't give you avenues to help yourself...

One final comment should be made about the volunteer contributions of people with low incomes. How people get involved in doing volunteer work is a critical part of the process. People like to be helped and supported to contribute to the community, not forced to help because they are on government assistance. They feel that forcing volunteer work on them will not improve their self-esteem or help build the community.

PROMOTING EMPOWERMENT

Health promotion is mostly about being in control of your life. People at the focus groups said there were a number of factors that help you get control of your life.

Some people said that feeling in control as adults depends a lot on having had a healthy childhood. Good parenting gives you self esteem and confidence. Others felt that having control is a decision that only you can make. You have to take control of your life by yourself.

Another way that people believed you could get control is through the respect and recognition that you get from doing things for and giving to others:

> *more or less when people tell you when you've done something good...when I know I've helped these kids (children in the STAR program)*
>
> *when you give advice and people take it, it's nice to know you've helped somebody*
>
> *when I show people that I can do it (accomplish something)*

Others felt that having support in times of crisis gives you control. One person said that he knows he cannot always help himself but likes knowing he can trust his friends to help him.

Having the right information and resources and being able to make decisions about your life were also seen as very important to gaining control. Learning skills such as problem-solving, in a supportive setting, is also very important.

CREATING ORGANIZATIONS THAT WORK

The people in the focus groups were asked how organizations could be more responsive or helpful. Many times people answered by telling us about the good things done by the organizations that arranged their focus groups or other organizations they have been involved with.

What people said most often is that they want a sense of community, belonging and "family". People want to belong to groups that make them feel special and important.

> *People come and go here, but just because you've gone you're not forgotten. You can come and go; we just welcome people back. No matter who comes and who goes there's a spirit here that stays and just continues; people come and they go but there is always a sense of belonging here.*
>
> *I feel strongly that there is a sense of family here, a sense of belonging. You don't have to earn your way here, you are accepted the way you are. Your gifts and talents are appreciated and your faults, your flaws and your shortcomings are downplayed.*

People in the focus groups said that professional organizations need to be caring. They must not judge people; people must be accepted for who they are. For example, several people said that they did not like having to "pretend to be religious" to get help from some organizations. If there are rules, they should make sense or they will not be followed. Also, people's gifts and skills must be supported and used. These points are echoed in these quotes:

> *They don't give up on you here. When I first did start here I said "I can't do these things" (and people) said "Oh yes you can!", and they stuck by me ... when you see that people care and stick by you so that you can do it ... they still do that today. That's what I like about this place ... they never give up on you.*
>
> *I like learning different things. I'm in the collective kitchen. I learn cooking different meals and now the North End clinic is getting a garden for us and now I'm learning different kinds of vegetables and different spices and I'm looking forward to that ... I'm doing something with people and I like working with people.*
>
> *When I feel free to be myself and when I know they won't make me feel humiliated ... I don't have to question myself and ask "should I say this?"*
>
> *(Help is best) when it comes from the soul and not the brain.*

Groups that are organized by people with low incomes (self-help groups) were seen as empowering for the people who are involved.

> *If I wasn't with these groups, I would end up in the psychiatric hospital.*
>
> *Before, I dealt with a lot of anger and resentment (at being a consumer/survivor) and I reached the point where I got so discouraged. Now I feel stronger and more hopeful. This (group) is the best thing that's happened. I don't know what I would do without it.*
>
> *...makes me feel that I'm part of a family ... I need them and they need me ... we're like a family and not an institutionalized place.*
>
> *We treat people like people - not welfare recipients.*
>
> *All of our friendships have formed out of this place ... we know how far we can push each other.*
>
> *It's a chance for friends to get together, support each other and help each other with problems.*

These groups are run by the members for the members. They promote self-help. The members make the decisions about how the groups are run. The rules of the group are made and fully supported by the members. People see that they are responsible for each other and that if the rules are broken everyone will be affected. Members trust the support and advice that is given to them because it is given by people just like themselves who have been in the same situation. The information that is given is practical and relevant. Each person's skills are used and appreciated. In one grassroots organization, a woman is valued for her contribution of emptying the ashtrays. This is what she can do for the group and it is appreciated. One person said:

> *The worst thing you can do to a person is ignore them.*

People in the focus groups also described an ideal organization. Often this was described as a "one stop shopping" model. People could go to a central place and find a range of services such as educational courses, drop-in and recreational programs. These organizations would be small and open every day so that "people (would) feel like they're doing something important." They would have long-term funding and would have needed financial supports such as bus tickets and child care.

OUR COMMUNITY'S STRENGTHS

Building strong communities is about knowing what strengths and skills exist and bringing the assets of people, associations and institutions together. During our project we heard about one example of this "capacity building" process by an organization. One person who volunteers at a community centre enjoys cooking and being with senior citizens. The organization supports this person by having her prepare meals every week for a senior's program.

In this Plan, we were not able to work on connecting the capacities of individuals and groups. However, we did identify some of the strengths of the community. The strengths of the community are in its public and community services. There are also strengths in its people and its green spaces and the environment. However, some people did not like anything about Hamilton-Wentworth or where they live.

PUBLIC SERVICES

A. Public library system
   This was the place that people in the focus groups mentioned most often as being important to them. The fifth floor of the downtown library got special mention. The Picton library was called "the only oasis of culture in this area (the north end)". People said that libraries are good places for information and important places for the development of the community.
B. Hamilton Street Railway
   Many people liked the extensive bus system.
C. Copps Coliseum
D. Recreation centres
E. The health care system and its services
F. The education system

COMMUNITY SERVICES

All of the groups that arranged the focus groups were seen by the participants as community assets. Many other groups or services were also mentioned, including:

Vocational Rehabilitation Services
North Hamilton Community Health Centre
Sackville Hill Senior's Centre
Child and Adolescent Services
Wesley Urban Ministries
Public Health Department
the VAN Program
Neighbour to Neighbour Centre
Red Cross Grocery Service
Good Shepherd Centre

GREEN SPACES AND THE ENVIRONMENT

The Red Hill Valley, Bayfront Park, Confederation Park and other parks within Hamilton-Wentworth were mentioned. Bayfront Park was mentioned many times. Others said "it's a nice city to walk around".

OTHER COMMUNITY ASSETS

Focus group participants also enjoy:

A. the Hamilton Market
B. the North End ("Hamilton's Best Kept Secret")
C. the access to shopping areas and community services
D. the size of Hamilton-Wentworth (it's not too big; "the people who live on the streets still have a face and a name.")

THE PEOPLE OF HAMILTON-WENTWORTH

Focus group participants said that the people of Hamilton-Wentworth are friendly and open minded. Others like the different ethnic groups in the community. Some like the cooperation between agencies and grassroots groups - "they respect what each has to contribute". Another person said "it's a community with a heart ... people give generously".

SUGGESTIONS FOR HEALTH PROMOTION FUNDING

Participants also made creative and practical suggestions on how to spend health promotion funds. There were some general themes such as education and practical skill development, projects that promote awareness of services and information, preventative programs, social support programs and advocacy programs.

People who took part in the focus groups were interested in learning and developing themselves. They want to learn practical skills they can use in everyday life. Learning skills that will not be used is a waste. For example, learning computer skills would not help a person who will never be in a position to use a computer.

Some suggested areas for education and skill development are:

- parenting
- cooking
- math and English
- self esteem programs
- CPR courses
- job clubs
- sex education
- food shopping tips
- weight loss programs
- coping with stress
- craft courses
- retirement planning
- health education (mental and physical health)
- budgeting (people debated whether budgeting is the problem or if lack of money is the problem)

People also said that funding for programs that help people find out about services is important. This information was also found in the research reports that were reviewed. People found it frustrating and confusing to search for information or find services. People also said that social service staff sometimes "tell me what they want me to know" and do not always give all the information. Sometimes, it is not clear which groups of people are entitled to receive services.

Programs which prevent health problems from starting also need funding. One person said "that prevention is a whole lot cheaper than intervention." Examples of this were services that could prevent the re-hospitalization of consumers or survivors of mental health services and programs that prevent young people from living on the streets.

As was said earlier, people want a sense of community and belonging. This is essential to their health and well-being. It is not surprising that people in the focus groups recommended funding for programs that offer social support. One person who has artistic skills said this about the value of social support:

> *(it provides) me with a social outlet that keeps me happy and provides me with inspiration to paint and write.*

The final suggestion made by many people was to fund advocacy programs. Advocacy programs provide help and support or can fight to change situations that do not seem fair. Advocacy happens in many ways - through education, support and social change. Many felt that advocacy is needed to change the systems, policies and attitudes that hurt them. They also felt that advocacy for social change needs long-term funding and large amounts of funding so that they can hire lawyers, buy computers and get in touch with large numbers of people. Others were not sure about funding programs for advocacy because it does not immediately make their lives better and because it is frustrating. One person felt "powerless" when thinking about advocacy while another said that "you're banging your head against the wall." At the same time, they recognized how important advocacy is to changing their circumstances.

People also had recommendations for funding for specific groups of people with low incomes. We did not have enough time to talk about these ideas with people at the focus groups, but these are some of the suggestions that were made.

YOUTH

- more programs for 15-19 year olds
- dance clubs for youth
- a community centre that is open on weekends and weeknights with a range of services (especially in east end Hamilton)

SINGLE PEOPLE AND SINGLE PARENTS

- education on physical and mental health
- emotional support programs to cope with being on assistance
- programs that help you get off government assistance
- supportive counselling for children on assistance who may have behavioural or educational problems

PERSONS WITH PHYSICAL DISABILITIES

- programs to educate employers and the general public about the capabilities of people with physical disabilities
- programs that produce information or tapes in braille, etc.
- support groups for family members

CONSUMERS OR SURVIVORS OF MENTAL HEALTH SERVICES

- social support and recreational programs
- education on mental illness and information on finding and using services
- programs for people who are coming out of hospital and need to be reintegrated into the community
- self help programs
- community gardens

PEOPLE FROM DIVERSE CULTURAL BACKGROUNDS

- programs that support people adjusting to changes because of moving to this country
- family centred programs
- support groups for women
- services available in many languages

"STREET PEOPLE"

- education and sensitivity training for professionals (one person was discharged from a hospital with no shoes in the rain)
- medical information (pneumonia, TB, lice, diabetes)

SENIORS

- retirement planning
- cooking and dietary information
- social support

Suggestions for the Health Promotion Funding Process

Other recommendations were made about the health promotion funding process. It was suggested that half of the funds be set aside for grassroots groups. Grassroots groups are groups that are organized by people with low incomes. Workshops should be provided to teach grassroots groups about writing proposals to get funding. It was also suggested that grassroots groups should help design the funding application forms and grassroots people should have input in all of the funding applications that are sent in. Funding also should be given first to groups that already exist. This means that funding should not go to new groups that want to do what other groups are already doing. The community should also be told which groups get funded.

Other Issues That Came Up During Our Project

Four other issues were also mentioned in the focus groups. As in most of the reports we reviewed, people said that no more research on poverty is needed and that action must be taken to get rid of poverty and its effects. One person said "they've spent thousands of dollars studying ... and now the reports have vaporized."

A second issue that came up is that community resources, like schools and churches, need to be better used. People said that a sense of community is both a feeling and a place. Places are needed for communities to grow. Churches and schools are best because they are found everywhere. Some women from diverse cultures said that in the countries they came from "schools are the centre for community life". Also, "in my country, churches are always open, here all the churches are closed." Some suggested that churches should be open in the winter for people to sleep. Young people suggested that schools be open on weekends and weeknights for programs.

People at the focus groups also said that they notice when organizations do not work well together. They notice, for example, when different social services programs do not tell each other about what they are doing. People strongly supported organizations working together.

Lastly, people shared their experiences of living on government assistance. None of them had planned to live on government assistance. A personal crisis, an illness, discrimination, a lack of jobs and a refusal by our society to use the skills of immigrants have put many people on assistance, and keep them on assistance. People are also kept on assistance because of the lack of supports and incentives to get off.

The effects on self-esteem can be harmful. People said:

- *I'm a throw away*
- *(we're considered) bums, trash, drunks, drug addicts, dirty*
- *politicians need to stop cutting us down. Instead of saying we're the problem, they need to remember the economy is the problem*
- *kids shouldn't worry where the next bag of milk will come from*
- *you need to be accepted or you start life on the wrong foot (referring to children whose parents are on assistance)*
- *the government owns you (one man was told this by a social assistance worker)*

Fortunately, some (but not enough) people know they are valuable.

- *you don't have to have a job to be a decent person and you don't have to have a house on the hill to be a decent person.*
- *our kids are not disadvantaged; they get more love than people with two jobs!*

Our Community's Strengths - the Views of Service Providers

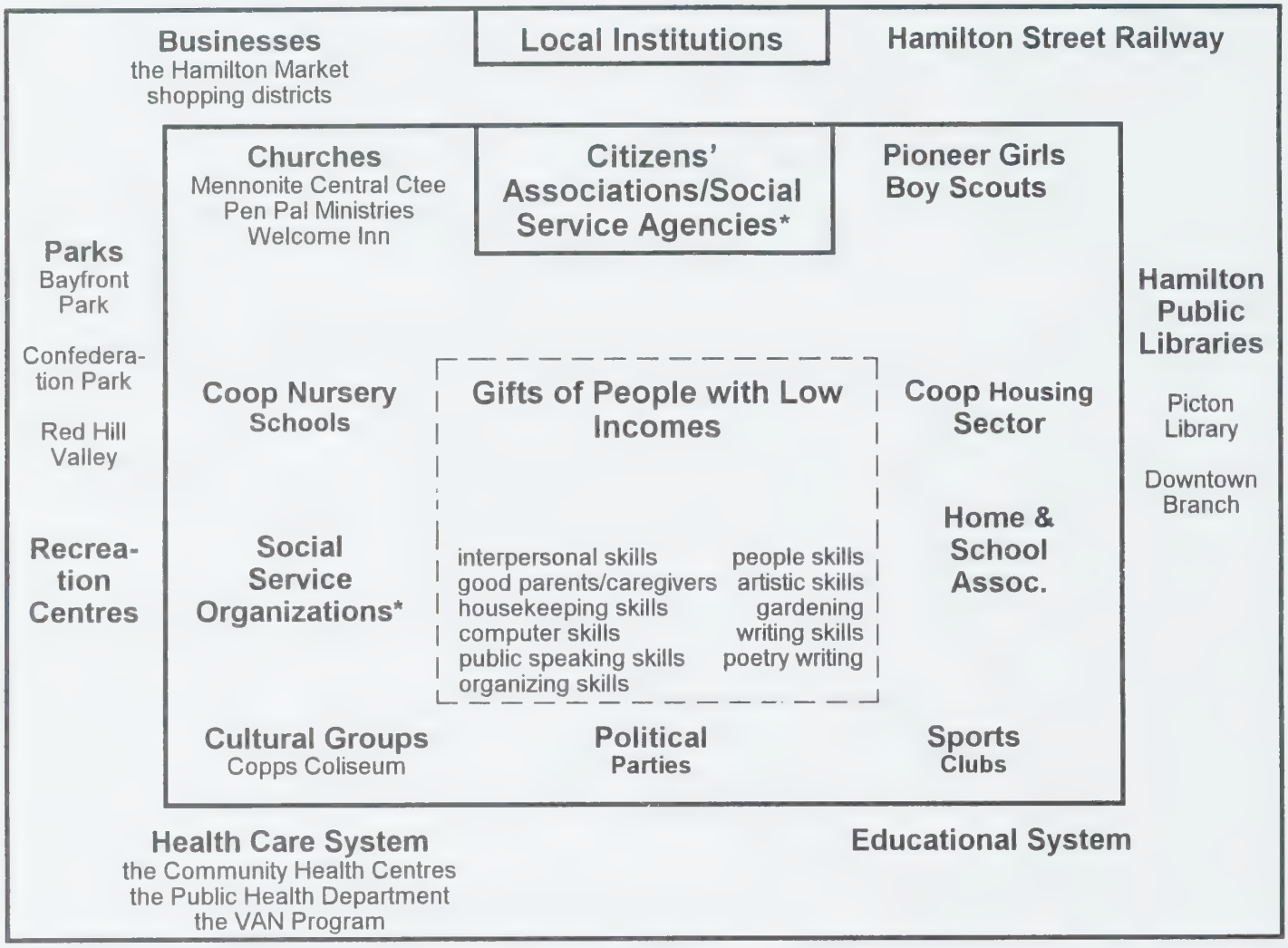
Service providers were the key informants in this project. They were asked about projects or services that were good examples of health promotion. Many were mentioned and are:

- Kidestrians (an injury prevention program)
- the Public Health Department
- the community health centres
- Jewish Women's Council program on breast cancer awareness
- Community Parent Education Program
- the community development work done by groups helping immigrants and refugees
- Crown Point Neighbourhood Project
- Bay Area Restoration Council
- Ferguson Street Citizen Planning Project
- Big Brother's Mentorship Program
- Child Abuse Council
- the AIDS VAN
- collective kitchens
- Social Housing Access Committee (SHAC)
- the Roomers and Boarder's Committee
- tenant organizations
- the Good Food Box Program
- Neighbour to Neighbour's Stepping Beyond Today program
- Salvation Army budgeting program
- the Welcome Inn
- the E/Merging project (board training for consumers/survivors of mental health services)

A Community Assets Map for Hamilton-Wentworth

This community assets map is based on what people with low incomes said about community and individual capacities and their volunteer involvements. When looking at this map it is clear that Hamilton-Wentworth is a community filled with people with many gifts and strengths! At the feedback session, one person said that the box with the gifts of people with low incomes should have broken lines to reflect how these gifts flow out into the community.

Figure 7



* see the report for a full list of the organizations; the community asset model by Kretzman and McKnight does not include social service agencies, but they were included here because many were identified during this project

Health Promotion Priorities - WHAT IS IMPORTANT

When the information from the reports, the interviews and the focus groups were combined the following were shown to be priorities for health promotion programming, policies and funding:

- projects that meet the basic needs of people, in creative and alternative ways
- projects that encourage social support and the development of communities
- self help and peer based projects
- projects that advocate for changes in systems and policies
- projects that make it easier for people to find out about community resources
- projects that develop practical skills and increase knowledge and education
- projects that prevent poverty or the harmful effects of poverty
- projects that recognize and build on the assets and contributions of people with low incomes and which involve them in the design, management and evaluation

Projects which research the general needs of people with low incomes are not a priority.

HEALTH PROMOTION PRINCIPLES - Guidelines to Follow

This list of health promotion principles were developed from our discussions with people with low incomes, service providers, and from written information about health promotion.

Health Promotion

- empowers individuals and communities
- supports the availability of choices and the right of people to make choices
- recognizes that the basic needs of food, shelter and clothing are priorities
- aims to distribute power and resources fairly for the well-being of all
- focuses on the well-being of the population as a whole
- uses many strategies like education, skill development and advocacy at the individual, group and community level
- includes the whole person - the physical, spiritual, psychological, emotional and social aspects
- respects the diversity of all people
- respects the uniqueness of all people
- is a life long process including all people in any state of physical or mental health
- is directed by the people, groups and communities involved
- encourages everyone to be responsible for good health
- encourages people and groups to work together
- values volunteering
- builds communities
- prevents problems from developing that can harm people and communities

UPDATING THIS PLAN

This Health Promotion Plan is the first one done by the Hamilton-Wentworth District Health Council. Future updates are needed, but they will have to be done with less staff time. We recommend that the Hamilton-Wentworth District Health Council update the Plan every two years and continue to use the socio-environmental model.

The planning process for this Plan included a review of existing research and reports, key informant interviews, and discussions with people with low incomes. It is recommended that these activities be done again when the report is updated. Each part is described below.

REVIEW NEW RESEARCH AND REPORTS

All new reports about health and well-being and poverty that are done after this Plan has been published should be reviewed. This review will tell us what the researchers have discovered about the problems in the community and what the current priorities are.

KEY INFORMANT INTERVIEWS

Discussions with selected community informants is also recommended. These people can be drawn from different sectors (grassroots groups, health and social services, labour, education,) and different professions (planners, community developers, front line staff, funders). This will help build partnerships and help identify specific priorities for health promotion.

GRASSROOTS INVOLVEMENT

We also recommend that an advisory or "reference" group of grassroots consumers be established. The purpose of this reference group would be to provide advice to the Health Promotion Committee about specific Health Promotion priorities. It could also advise on what further work is needed to update the Plan and how this work should be done.

People at the focus groups said that they wanted to be involved in updating the Plan. They felt that the most comfortable way to do this is through a group of their own peers. They also wanted to be sure that their input would be used and valued. Therefore, the relationship between the reference group and the Health Promotion Committee would have to be clearly worked out. For example, discussions about sharing information between the two groups and how decisions are to be made would be helpful to have at the beginning of the process.

DOCUMENTING NEEDS AND CAPACITIES

This report took the approach that focusing on the strengths and skills of people is the best way of empowering individuals and the community. The health promotion priorities were developed with this approach. We recommend that future Health Promotion Plans continue to take this approach, as well as consider the needs of people with low incomes. Ideally, we need to do more than simply report on peoples' strengths and skills. What is really needed is for groups to work together to better use those strengths. This approach will promote the health of individuals and the community.

THE LESSONS WE LEARNED

As with any project, we had many struggles. Ours were:

1. We struggled with how and when to include people with low incomes in the project. Focus group members told us it is always best to include them at the beginning of the process and then the "how" will sort itself out. We did not know how to change our formal meeting structure to include people with low incomes. We also found it difficult to talk clearly about our goals, vision and about what health promotion is. For these reasons, we did not include people with low incomes at our regular meetings. We know we missed a great deal because people with low incomes were not included at the very beginning.

2. Health promotion is not understood the same way by everyone. It means many things to each of us. Sometimes there are problems because not everyone shares the same views, strategies or language about health promotion. This also happens among providers of health promotion services. However, people at the focus groups taught us that empowerment and the development of community are the goals of health promotion and that a variety of strategies can be used.

3. Health promotion is a term used by health professionals. Finding words and having a common understanding of what health promotion means to grassroots people, health professionals and professionals from other sectors is a challenge.

4. We need to develop ways to evaluate the effectiveness of projects that focus on "community building" and "empowerment". The Health Promotion Committee will need to follow this up since it has a new role to oversee projects which have been funded.

5. We did not use the capacity building model as it was meant to be used. In this model, lists of skills and assets are developed as a starting point for community development. We used the model simply to report on strengths and capacities. We know that both parts of the model are important.

6. It is vital to provide food, childcare and transportation to help people take part in a project like this.

7. There is already a lot of research and many recommendations about addressing the impact of poverty in the community. We need to find ways of seeing if something is happening with these recommendations.

8. Getting people to take part in our project was difficult if they did not already belong to a group or organization. More and different ways to reach these other people was needed, but we did not have enough time to do this.

RECOMMENDATIONS

1.0 Education and Advocacy

Poverty and its effects on health and well-being are serious problems in Hamilton-Wentworth. Because of this, we recommend:

1. that the Hamilton-Wentworth District Health Council take on an educational and advocacy role to respond to the problem of poverty by using the following approaches:

   a) that Council educate new members about health promotion, population-based health planning and the current health status of people with low incomes in Hamilton-Wentworth; also that Council participate in ongoing education in these areas

   b) that the Health Promotion Committee gather information with other community partners and give Council a yearly update on the health status of those with low incomes in Hamilton-Wentworth; also that this yearly health status report be published and distributed in the larger community and to key people and organizations

   c) that the Hamilton-Wentworth District Health Council begin to develop partnerships with other organizations including other planning groups to respond to poverty in a coordinated way

   d) that the Hamilton-Wentworth District Health Council encourage the Ministry of Health to recognize the importance of health promotion, and that the Hamilton-Wentworth District Health Council encourage the Ministry of Health to provide sufficient funding for the Healthy Community Grants Program.

2.0 Healthy Community Funding

With regard to the Healthy Community grants funding, it is recommended:

2.1 that the Hamilton-Wentworth District Health Council make poverty a long term priority for Healthy Community funding.

2.2. that the Health Promotion Committee give priority to proposals that:

- try out in new and original ways , projects that address people's basic needs
- encourage social support and the development of communities
- develop self-help and peer based projects
- develop practical skills and increase knowledge
- prevent the growth of poverty and the harmful effects of poverty
- make it easier to get information about community resources
- recognize and build on the assets and contributions of people with low incomes

2.3 that the Health Promotion Committee support "grassroots groups" in the Healthy Community Grants process by:

- working toward setting aside at least half of the Healthy Community funding for grassroots groups
- organizing a yearly grant writing workshop for grassroots groups
- identifying community resources to help grassroots groups in writing grant applications
- inviting groups that have received funding to an annual community meeting to discuss and evaluate the results of their projects
- starting discussions with local funders about ways to support the ongoing development of grassroots groups which receive funding

2.4 that the Health Promotion Committee let grassroots groups and health and social service organizations know which proposals have been funded.

2.5 that the Health Promotion Committee, in its role of monitoring Healthy Community Grants, develop ways to evaluate the results of individual and community capacity building projects

2.6 that the Health Promotion Committee set up a reference group of "grassroots people" to advise on health promotion priorities, the grants review process and ways to consult with people in the community

3.0 Updating the Health Promotion Plan

To keep the Health Promotion Plan up to date it is recommended:

3.1 that the Health Promotion Committee update the Plan every two years by reviewing new research and reports, interviewing key informants, and consulting with "grassroots people"

3.2 that the updates of the Health Promotion Plan report both community needs and capacities.

4.0 Implementation Strategies

To share the information from this report and to start to work on the issues that were raised in the Plan, it is recommended:

4.1 that the Hamilton-Wentworth District Health Council send this report and its recommendations to local health and social service organizations, churches, school boards, grassroots groups, local funders, planning bodies, the Ministry of Health and other relevant provincial ministries and local members of provincial parliament.

4.2 that the Hamilton-Wentworth District Health Council meet with local members of provincial parliament and regional politicians to talk about poverty and its impact on the population and policies that will respond to these issues.

4.3 that the Health Promotion Plan, and the principles of health promotion, be sent to all committees and task forces of the Hamilton-Wentworth District Health Council for use in their planning processes.

Footnotes

[1] Premier's Council on Health Strategy, Nurturing Health: A Framework on the Determinants of Health, 1991, pp 3-5

[2] Ottawa Charter for Health Promotion. "An International Conference on Health Promotion: The Move Towards a New Public Health", Canadian Journal of Public Health, 77 (1986), pp 425-427

[3] Labonté, Ronald, Health Promotion Theory and Practice: Background Material #1, Centre for Health Promotion, University of Toronto

[4] Ibid

[5] Labonté, Ronald, Health Promotion and Empowerment: Practice Frameworks, Centre for Health Promotion, University of Toronto, pp 55-76

[6] Kretzman, J., McKnight, J., Building Communities From the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets, Centre for Urban Affairs and Policy Research, Northwestern University, pp 1-11

[7] Harding, Michele, The Relationship Between Economic Status and Health Status and Opportunities: A Synthesis, Toronto, 1987, pp 1-49

[8] Cited in Premier's Council on Health Strategy, Nurturing Health: A Framework on the Determinants of Health, 1991, pp 1-2

[9] Liaw, K, Wort, S., Hayes, M., "Intraurban Mortality Variation and Income Disparity: A Case Study of Hamilton-Wentworth", The Canadian Geographer, 33:2 (1989), pp 131-145

[10] Cited in Rootman, I, "Inequities in Health: Sources and Solutions", Health Promotion 26 (Winter 1988), pp 2-8

[11] BC Ministry of Health and Ministry Responsible for Seniors, A Report On The Health of British Columbians: Provincial Health Officer's Annual Report. 1994

[12] Canadian Institute of Child Health, The Health of Canada's Children (1994), p 128

13 Warren, R., Health and Wealth, Premier's Council on Health, Well-Being and Social Justice, May 1994, p 6

14 Ibid, p 7

15 Pol, L. and Thomas R., The Demography of Health and Health Care. Plenum Press: New York, 1992, pp 341-343

16 Warren, R., p.10

17 Premier's Council on Health Strategy, Nurturing Health: A Framework on the Determinants of Health, March 1991, p 15

18 Ibid, pp 14-15

19 Cited in DeSantis, Gloria, Tracking Community Trends in Hamilton-Wentworth, December 1993, p 51

20 Ibid, p. 50

21 Personal Correspondence from Wesley Urban Ministries, September, 1995

22 Personal Correspondence from Neighbour to Neighbour Centre, September 1995

23 Personal Correspondence from The Good Shepherd Centre, September 1995

24 Personal Correspondence from the Salvation Army, September 1995

25 Personal Correspondence from Mission Services, September 1995

26 Conversation with the Hamilton-Wentworth Regional Economic Department, September 1995

27 Department of Regional Social Services, June 1995 and Second Quarter General Assistance Caseload Report, July 1995

28 Ministry of Community and Social Services, "Family Benefits Caseload in Hamilton-Wentworth Statistics," July 1995

29 Schofield, R. And Cook, P., Homelessness and Mental Illness in the Hamilton-Wentworth Region: Draft Report, June 1995, pp 5-6

[30] Pennock, M. And Foulds, R. Determinants of Health In Hamilton-Wentworth: A Comparative Analysis of Hamilton-Wentworth with Other Regional Municipalities, October 1994, p. 8

[31] Ibid, p. 28

[32] Ibid, p. 8

Bibliography

BC Ministry of Health and Ministry Responsible for Seniors. A Report on The Health of British Columbia: Provincial Health Officer's Annual Report, Victoria, B.C., 1994.

Bracht, N. (Ed.) Health Promotion at the Community Level. Gage Publications, 1990.

Canadian Institute of Child Health. The Health of Canada's Children: A CICH Profile. 1994.

DeSantis, G. Tracking Community Trends in Hamilton-Wentworth. Hamilton, Ontario, 1993.

Dickson, L, Heale, J. & Chambers, L. Fact Book on Health in Hamilton-Wentworth, Third Edition. Hamilton, Ontario, 1994.

Evans, R. G. & Stoddard, G. I. Producing Health, Consuming Health Care. Working Paper #90-6. Centre for Health Economics and Policy Analysis, McMaster University. Hamilton, Ontario, May 1990.

Evans, R., Barer, M. & Mamor, T. (Eds.) Why Are Some People Healthy and Others Not?: The Determinants of Health of Populations. T. R. Aldine de Gruyter, 1994.

Green, L. & Kreuter, M. Health Promotion Planning: An Educational and Environmental Approach. Mayfield, California, 1991.

Harding, M. The Relationship Between Economic Status and Health Status: A Synthesis: A Background Report Prepared for the Ontario Social Assistance Review Committee. Toronto, Ontario, 1987.

Health and Welfare Canada. Knowledge Development For Health Promotion: A Call for Action. Minister of Supply and Services Canada, 1989.

Kretzman, John P. & McKnight J. Building Communities From the Inside Out: A Path Toward Finding and Mobilizing A Community's Assets. Centre for Urban Affairs and Policy Research, Northwestern University, 1993.

Labonté, R. Health Promotion and Empowerment: Practice Frameworks. Centre for Health Promotion, University of Toronto. Toronto, Ontario.

Labonté, R. Health Promotion Theory and Practice Background Material 1 and 2. Centre for Health Promotion, University of Toronto, Toronto, Ontario.

Liaw, K.L., Wort, S. & Hayes, M. "Intraurban Mortality Variation and Income Disparity: A Case Study of Hamilton-Wentworth Region." The Canadian Geographer, 33:2, (1989), 131-145.

Ministry of Health. A Guide for Community Health Promotion Planning, 1993.

Pederson, A, O'Neill, M. & Rootman, I., (Eds.) Health Promotion In Canada: W. B. Saunders, 1994.

Pennock, M. & Foulds, R. Determinants of Health In Hamilton-Wentworth: A Comparative Analysis of Hamilton-Wentworth With Other Ontario Regional Municipalities. Hamilton, Ontario, 1994.

Pol, L. & Thomas R. The Demography of Health and Health Care. New York: Plenum Press, 1992.

Premier's Council on Health Strategy. A Vision of Health: Health Goals For Ontario.

Premier's Council on Health Strategy. Nurturing Health: A Framework on the Determinants of Health, March 1991.

Premier's Council on Health, Well-Being and Social Justice. Nurturing Health, 1993.

Premier's Council on Health, Well-Being and Social Justice. Health For All Ontarians: A Provincial Dialogue on the Determinants of Health, 1994.

Regional Municipality of Hamilton-Wentworth. Community Health: Discussion Paper II, Prepared for the Regional Chairman's Task Force on Sustainable Development. Hamilton, Ontario, May 1991.

Regional Municipality of Hamilton-Wentworth, Department of Public Health Services. Population-Based Health Promotion: A Community Learning Package. Hamilton, Ontario, 1994.

Rempel, S. Homelessness In Hamilton-Wentworth. Hamilton, Ontario, 1992.

Rootman, I. "Inequities in Health Services and Solutions." Health Promotion, 26 (1988), 2-8.

Schofield, R. & Cook, P. Homelessness and Mental Health in the Hamilton-Wentworth Region Draft Report. Hamilton, Ontario, June 1995.

Syme, S. L. & Berkman, L. F."Social Class, Suspectibility and Sickness," American Journal of Epidemiology, 104, (1976), 1-8.

Warren, R. Wealth and Health, Health and Wealth. Queen's Printer for Ontario, 1994.

APPENDICES

HEALTH PROMOTION PLAN

BACKGROUND

The Ministry of Health recently identified the need for comprehensive health promotion planning by District Health Councils. The proposed Health Promotion Plan will respond to this need and will also complement the extensive health promotion initiatives already being undertaken by other organizations and groups in our community.

The present Health Promotion Committee will serve as a steering committee for this project. The Committee has adopted the following definition of health promotion:

> "Health promotion is the process of enabling individuals and communities to increase control over the factors which protect their health, thereby improving their health. The factors which determine the health of individuals and their communities are both individual and societal, including the social, environmental and economic structures of our communities. Individuals and communities need peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity as a prerequisite to health." (Ottawa Charter, 1986)

PURPOSE

To develop a community supported Health Promotion Plan which will provide a framework, with goals, strategies and community priorities, to guide and enhance health promotion planning and decision making within the Hamilton-Wentworth District Health Council and within the Hamilton-Wentworth region.

SCOPE

It is recognized that the broad determinants of health, which include living and working environments, social support, individual behaviour and genetic makeup[1] have an impact on the health of individuals and communities. Health will be defined using a socio-environmental model. The issue of poverty as it relates to various groups of people will be examined within the context of this model, as those who live in conditions of poverty are at greatest risk for poor health and well-being. Specific strategies for reducing the impacts of poverty, such as empowerment, community development and advocacy will also be explored.

---

1 *Nurturing Health. Premier's Council on Health, Well-Being and Social Justice. 1993*

PRINCIPLES

The following principles are deemed essential to the Health Promotion Plan and the accompanying process, and will form a governance framework.

- the Health Promotion Plan will focus on the strengths which exist in our communities
- the Health Promotion Plan will identify the gaps which exist in our communities
- the Health Promotion Planning process will achieve community support
- the Health Promotion Plan will promote increased control by individuals and communities over the factors that affect their health
- the process will be easily accessible so that all those who want to participate will have meaningful input into decision making
- the process will include both the formal and informal networks of stakeholders in our community
- the Health Promotion Plan will recognize the role and contribution of those who currently provide health promotion services, such as health organizations, community agencies and advocacy groups
- the Health Promotion Plan will make effective use of resources, particularly volunteer assistance
- the Health Promotion Committee will endeavour to have broad representation so that all facets of the determinants of health can be explored
- the Health Promotion Plan will focus primarily on strategies which have wide application to the general population
- the Health Promotion Plan will define a process that can be easily replicated so that the emerging health promotion needs of the community can be identified regularly by the Hamilton-Wentworth District Health Council
- the Health Promotion Plan will be written in "plain language"
- the Health Promotion Plan will identify priorities that will guide the Health Promotion Committee's proposal review process
- the Health Promotion Plan will identify achievable outcomes that will be offered to health promotion providers and the broader community
- the Health Promotion Plan will ensure that health promotion principles are well integrated into the activities of the Hamilton-Wentworth District Health Council.

- the Health Promotion Plan will encourage linkages between health promotion providers.
- the Health Promotion Committee will evaluate the process used to develop the Health Promotion Plan.

DELIVERABLES

It is anticipated that the Health Promotion Plan will:

1) identify those involved in promoting the health of individuals and communities

2) identify goals in health promotion

3) identify community priorities in health promotion

4) facilitate the development of a set of health promotion principles which the Hamilton-Wentworth District Health Council, community groups and government bodies can use in health promotion planning, project development/review and implementation

5) identify a mechanism for the Hamilton-Wentworth District Health Council to regularly and easily identify health promotion priorities so that they can be reflected in the grants review process

Appendix B

Phase I Key Informants

Debbie Bang	St. Joseph's Community Health Centre
Helen Hale-Tomasik	Department of Public Health Services
Jane Underwood	Department of Public Health Services
Lenore Dickson	Health Priorities Analysis Unit
Jody Orr	United Way of Hamilton-Wentworth/Burlington
Ann Scott	Department of Regional Social Services
Rosemary Foulds	Department of Regional Social Services
Gary Michaluk	AATD
Harry Nigh	Welcome Inn
Ruth Martin	Welcome Inn
Mike Hannigan	Welcome Inn
Judith McCullough	Hamilton Community Foundation
Dorothy Bartalos	Hamilton Community Foundation
Lee Staats	Native Regional Indian Community Centre
Shelley Rempel	Housing Help Centre
Lesley Russell	Community Information Services
Mike Pennock	Social Planning & Research Council
Don Jaffray	Social Planning & Research Council
Mary Seigner	North Hamilton Community Health Centre
Ines Rios	St. Joseph's Immigrant Women's Centre
Andrea Horvat	McQuesten Legal and Community Services
Abe Friesan	Addiction Research Foundation
Anne Scione	Community Adolescent Network
Bob Bisson	Centre de santé et de services communautaires Hamilton
Mark Bekkering	Planning & Development Department, Regional Municipality of Hamilton-Wentworth

Appendix C

Phase II Key Informants

Wendy Roy	St. Matthew's House
Kelvin Honsinger	Mission Services of Hamilton, Inc.
Thomasina Hansen	Mission Services of Hamilton, Inc.
Denise Arkell	Neighbour-to-Neighbour Centre
Rose Mallais	Neighbour-to-Neighbour Centre
Birgitt Bolton	Wesley Urban Ministries
Br. Richard McPhee	Good Shepherd Centre
Susan Roach	Mental Health Rights Coalition

INVENTORY OF COMMUNITY REPORTS

A) CHILDREN

1. How Do They Fare; Giving Children Hope, October 1993
2. * How Do They Fare; Response Committee Report, August 1994
3. Summary Report of Student and Parent Focus Groups, Spring 1994
4. School/Child Nourishment Task Force, September 1994

B) YOUTH

1. Community Street Youth Task Force Report, January 1990

C) FAMILIES

1. Neighbour to Neighbour Parent Survey, Winter 1994

D) WOMEN

1. Parent Child Program Needs Assessment (St.Joseph's CHC) 1993
2. Housing Needs of Women in Hamilton-Wentworth, June 1994
3. Women's Wellness Project, November 1993

E) SINGLES

1. The Forgotten Poor: The Plight of Low Income Individuals in Hamilton-Wentworth, Summer 1993
2. Roomers and Boarders Task Force, May 1994

F) PERSONS WITH PHYSICAL DISABILITIES

1. Integrating People With Disabilities Into Every Aspect of Living (IDEAL), September 1991

G) SENIORS

1. Services For Seniors Study; Mapping the Way To The Future For The Elderly, October 1988
2. Senior Citizen Services in Flamborough, September 1989
3. Report on Needs Survey of Senior Citizens in Ancaster and Glanbrook, July 1990
4. Report on Needs Survey of Senior Citizens in Stoney Creek, June 1990

* Summary not completed

H) MENTAL HEALTH

1. A Mental Health Plan for Hamilton-Wentworth, June 1992
2. *Mental Health Implementation Task Force, May 1994

I) HOMELESS PEOPLE

1. Program Review of The Emergency Night Time Drop In Program (Wesley Urban Ministries), June 1994
2. Wesley Urban Ministries CHC Proposal, October 1994

J) PEOPLE OF DIVERSE CULTURES

1. A Community Based Needs Assessment of Settlement & Integration Service in Hamilton-Wentworth, April 1992

K) ACROSS POPULATIONS

1. Determinants of Health in Hamilton-Wentworth, October 1994
2. Chairman's Task Force on Sustainable Development: Community Focus Groups, June 1991
3. Social Safety Net: Voices of Concern, December 1994

L) COMMUNITY PRIORITY SETTING DOCUMENTS

1. Health and Social Services Priority Setting, 1993
2. United Way 1993 Community Consultation on Priorities For Demonstration and Development for Hamilton, 1993
3. Community Consultation on Human Service Priorities Final Report, April 1995

Name of Report/ Author/Year	Target Group	Methodology # of Participants	Themes/Needs/Recommendations Consumer Perspective	Themes/Needs/Recommendations Provider/Other Perspective
<u>How Do They Fare: Giving Children Hope</u> Report to the Food & Shelter Advisory Committee October 1993 <u>How Do They Fare</u> Response Committee	children and the effects of the recession this is a workshop report and a response; the response is an inventory of services that exist to respond to the recommend-ations made at the workshop	- workshop participants n = 62		- prenatal education - need parent support groups - increase awareness of services by providers - need creativity to keep children with behavioural problems in programs - continuity of service - increased awareness of impact of poverty - more recognition/services for 16 and 17 year olds - guaranteed annual income - create new vision for children's services - alleviate hunger - use the media more effectively - enhanced public/consumer input

Name of Report/ Author/Year	Target Group	Methodology # of Participants	Themes/Needs/Recommendations Consumer Perspective	Themes/Needs/Recommendations Provider/Other Perspective
Summary Report of Student & Parent Focus Groups Spring 1994 Public Health Department	students and parents in all school boards (include a mix of urban, rural, high risk, multicultural and affluent areas)	36 modified focus groups n = 767 students from grades 2 to 8 n = 60 parents	1 Basic needs (housing, clothing and shelter 2 body image (weight, physical appearance) 3 death and dying (death/fear of death of family member or pet) 4 environment (pollution, neighbourhood issues) 5 family relationships (anything to do with family member) 6 finances/job (income, money, jobs in the future) 7 healthy lifestyle (includes nutrition, dental, hygiene, physical exercise, sexuality) 8 leisure activities (playing, recreation, fun) 9 peer relationships (positive or negative relationship issues with friends/classmates) 10 personal safety/violence (bullying, family violence, fear of abduction, violence in society) 11 physical health (health status, specific diseases) 12 school (relationships with school personnel, academic issues) 13 self-esteem (how children feel about themselves 14 substance abuse/smoking	

Name of Report/ Author/Year	Target Group	Methodology # of Participants	Themes/Needs/Recommendations Consumer Perspective	Themes/Needs/Recommendations Provider/Other Perspective
School/Child Nourishment Task Force September 16/94	school aged children (under 21), elementary and secondary, needing nourishment	input obtained from: - 2,200 people (elementary/secondary school students, parent groups, food bank clients, school staff) - obtained through questionnaires, focus groups, interviews and a community forum	(Not exhaustive list) - that the Region reaffirm its involvement in nourishment programs - the report be forwarded to the Boards of Education - progress report and workplan regarding nourishment programs be brought to Regional Council at the start of each term - a theme identified but outside of the scope of the task force is the need for public education on the need for nourishment programs	

Name of Report/ Author/Year	Target Group	Methodology # of Participants	Themes/Needs/Recommendations Consumer Perspective	Themes/Needs/Recommendations Provider/Other Perspective
Community Street Youth Task Force Report by Members of the Community Street Youth Task Force January/90	Street Youth (13-25) yrs	a) Community mapping exercise of services b) needs assessment conducted with youth through: I one-to-one conversations ii public meetings iii development of life histories n = 82 c) needs assessment of parents of street youth through radio talk show and one parent's story n = 6 d) service provider symposium n = 120	**PUBLIC MEETINGS** 1. lack of shelters for those under 16; want a clean, safe, accessible and supportive residence 2. lack of money 3. lack of job accessibility 4. lack of meaningful support 5. lack of information on community resources 6. need for free medical facilities; place to wash clothes, eat and have recreation **ONE TO ONE (Actual Street Youth)** 1. need for a "safe house" (emergency) and long term adequate housing 2. income 3. employment 4. health care - "hassle free", "drop in for first aid" 5. food 6. clothing 7. support 8. information	**PARENTS OF STREET YOUTH** 1. self help groups for parents 2. more support of parents by agencies which serve youth **PROVIDERS** Identified 2 main problems: a) problems with youth and the family (eg lack of education; low self-esteem; economic stress; lack of parental b) guidance; etc.) problem with the larger system of services (eg lack of housing; long waiting lists, service fragmentation, etc.)

Name of Report/ Author/Year	Target Group	Methodology # of Participants	Themes/Needs/Recommendations Consumer Perspective	Themes/Needs/Recommendations Provider/Other Perspective
Neighbour-to-Neighbour Parent Survey Winter, 1994 (Program Needs Assessment)	parents using Neighbour to Neighbour Food Bank services	- survey (assistance in completion was available if requested) n = 134	- interest in increasing knowledge of children's health, safety & behaviour - identified that the best strategies by which to achieve the above include a newsletter, guest speakers and a phone line	

Name of Report/ Author/Year	Target Group	Methodology # of Participants	Themes/Needs/Recommendations Consumer Perspective	Themes/Needs/Recommendations Provider/Other Perspective
Parent Child Program Needs Assessment by the St. Joseph's Community Health Centre 1993	low income women and limited budget families with infants	focus groups of consumers and providers n = ?	**BARRIERS TO PARTICIPATION** - lack of childcare - lack of transportation - cost - unaware of service - perceived judgemental attitude of professionals **GAPS IN SERVICES** - limited postnatal support - need better preparation when leaving hospital after birth of a child - little support for certain groups of mothers (eg. Older moms, moms with preemies) - limited summer service	**BARRIERS TO PARTICIPATION** - Lack of childcare - Lack of transportation - Cost - Inconvenient time - Unaware of service - Perceived judgemental attitude of professionals - misconceptions about agencies - feelings of powerlessness - fear of group activities - limited literacy skills - rigid rules - waiting lists **GAPS IN SERVICES** - limited postnatal support - less time for teaching of infant care needs in hospitals - limited support to working poor, multicultural groups, teens going back to school - no weekend assistance - limited resources in certain areas

Name of Report/ Author/Year	Target Group	Methodology # of Participants	Themes/Needs/Recommendations Consumer Perspective	Themes/Needs/Recommendations Provider/Other Perspective
Housing Needs of Women in Hamilton-Wentworth Housing Help Centre June 1994	low income women in need of housing	- qualitative research - combination of personal interviews, discussion groups and focus groups - included consumers and providers - n = 42 consumers - combination of diverse group of women including single, older, native and immigrant women and survivors of abuse and psychiatric survivors	- lack of housing choices for low income women - lack of safety and security in their homes, buildings and in the streets - absence of "community", therefore sense of isolation - difficulty in completing housing searches - experience discrimination - inadequacy of non-profit housing (eg. Waiting lists) - inadequate supportive housing - inadequate service provision - inadequate emergency housing; especially no family shelters (the above reflect the comments of both consumers and providers)	- indicated that the issues identified exist for men as well

Name of Report/ Author/Year	Target Group	Methodology # of Participants	Themes/Needs/Recommendations Consumer Perspective	Themes/Needs/Recommendations Provider/Other Perspective
Women's Wellness Project HWDHC November, 1993	diverse groups of women in Hamilton-Wentworth (native, poor, immigrant, seniors, care-givers, women with low literacy) n = 71	focus groups; qualitative research	- identified that all of the broad determinants of health have an impact on one's health - dissatisfaction with physicians - wellness includes physical, emotional, spiritual and social components as well as a good sense of self and personal and educational supports to enhance coping - stress is a major concern - having personal control is important to wellness	n/a

Name of Report/ Author/Year	Target Group	Methodology # of Participants	Themes/Needs/Recommendations Consumer Perspective	Themes/Needs/Recommendations Provider/Other Perspective
The Forgotten Poor: The Plight of Low Income Individuals in Hamilton-Wentworth by Neighbour to Neighbour Housing Help Centre St. Matthew's House Hope Haven Homes Public Health Dept. THIAC Summer 1993	men and women with no dependent children or spouses between the ages of 16-60 years	1. Focus groups and interviews n = 55 men/8 women	1 Frustration (with lack of work, money, discrimination) 2 problems with training and education 3 limited employment activities 4 problems with housing (affordability, L&T problems, quality, choice, privacy) 5 lack of income 6 lack of social/recreational opportunities 7 social services - lack of support/time by case managers 8. health (mental and physical)	the 5 agencies involved identified that they could not meet the following needs: - transportation - clothing - financial assistance - furniture - housing - drop-in services - recreation

Name of Report/ Author/Year	Target Group	Methodology # of Participants	Themes/Needs/Recommendations Consumer Perspective	Themes/Needs/Recommendations Provider/Other Perspective
Joint Report of the City of Hamilton and the regional Municipality of Hamilton-Wentworth Roomers and Boarders Task Force May, 1994	people living in rooming/ lodging houses (can be low income people, people with psychiatric illnesses and those released from correctional facilities, etc; are often single)	- task force examination of this issue; developed study groups		- numerous recommendations concerning license and inspection changes - need for increased education among those living in rooming houses, landlords and service providers - that health/social service providers examine their role in providing support to those who live in rooming houses - need for increased advocacy - recommend an implementation sub-committee

Name of Report/ Author/Year	Target Group	Methodology # of Participants	Themes/Needs/Recommendations Consumer Perspective	Themes/Needs/Recommendations Provider/Other Perspective
Integrating People with Disabilities Into Every Aspect of Living IDEAL A Report of the Long-Term Care Subcommittee Regional Advisory Committee for the Physically Disabled September 1991	adults with disabilities in Hamilton-Wentworth	- 20 consumer focus groups n = 103 - 6 meetings with caregivers n = 15 - forum for service providers - public meeting held for those concerned with children and disabilities	- major finding is that the service delivery system is "malfunctioning and cumbersome" 1. **COORDINATED SERVICES** - must be provided with same access to mainstream services (eg. housing, recreation, etc.) - need interlocking and linked services (eg. funding be provided to encourage collaboration; agencies be linked by automated means) - simplification of the process of application for services - easier access to services (with several points of access) - decisions need to be consumer driven with input from caregivers 2. **COMPREHENSIVE SERVICES** - need spectrum of services with different delivery methods - need physically accessible services - implement SARC Report - pensions - eligibility should be based on need not nature of disability, etc. 3. **ACCOUNTABILITY** - have consumers involved in planning, evaluation, quality management - need more information on what services are available - need consistent standards of service - need community wide data base 4. **SERVICE COORDINATION AGENCY** role would be assessment, admission or intake; will provide information & referral; ombudsman	**INFORMAL CAREGIVERS** Specific Themes Identified. 1 prejudice and discrimination 2 service delivery (service fragmentation/coordination, lack of information) 3 in-home support services 4 hospitals/institutional care (waiting lists for rehab, lack of staff knowledge) 5 housing 6 environmental accessibility 7 transportation 8 income (loss of privacy, pride, extra expenses) 9 employment (difficult to maintain as a caregiver) 10 personal and family responses (lonely, isolated) 11 education 12 recreation/leisure (respite care) 13 advocacy **SERVICE PROVIDERS (by SPRC)** 1 need increased human rights protection and advocacy 2 supports for informal caregivers 3 compensatory home supports 4 adequate mobility and transportation 5 assistance with life cycle developmental issues 6 economic security 7 appropriate & affordable shelter 8 safety and security **PRIORITIZED NEEDS (from Stakeholders Meeting)** 1 delivery of services-coordination, individualized programming 2 home support services 3 housing 4 environmental accessibility 5 transportation 6 income 7 education 8 advocacy
		Themes/Needs/Recommendations Consumer Perspective (continued)		
		SPECIFIC ISSUES IDENTIFIED - prejudices and discrimination - service delivery system (lack of information, centralized service access) - support services (must be flexible, lack of home supports) - health care - housing (issues in design, location, availability, cost and policies) - environmental accessibility (the community needs to be accessible) - transportation (this restricts access to involvement in community) - employment - income (confusion about pensions, inadequate pensions/incomes) - family (financial and emotional strain) - education (of the public, professional caregivers and self-education) - recreation and leisure (out-of-town, local public activities and clubs) - advocacy		

Name of Report/ Author/Year	Target Group	Methodology # of Participants	Themes/Needs/Recommendations Consumer Perspective	Themes/Needs/Recommendations Provider/Other Perspective
Services for Seniors Study Mapping The Way To The Future For The Elderly HWDHC October, 1988	senior citizens (65+) in Hamilton-Wentworth	survey of over 5,000 beds in institutional facilities survey of 700 seniors workshops n = 142 telephone survey n = 677 survey of over 100 agency and government representations	**FROM THE SURVEY OF SENIORS** transportation availability of home support services awareness of and access to home support/maintenance services isolation costs of medical and dental care affordable housing caregiver support	

Name of Report/ Author/Year	Target Group	Methodology # of Participants	Themes/Needs/Recommendations Consumer Perspective	Themes/Needs/Recommendations Provider/Other Perspective
Senior Citizen Services in Flamborough September, 1989	senior citizens in Flamborough	survey of services by similar sized municipalities n = 7 inventory of agency services survey of seniors living in Flamborough n = 260	**NEEDS** 1 transportation (both public and volunteer transportation 3 more accommodation options (apartments and seniors apartments) 4 home support services (home maintenance, friendly visiting) 5 leisure and recreation 6 information and referral services and increased promotion 7 personal counselling 8 caregiver supports 9 neighbourhood security - 2% indicated that lack of money is a problem **RECOMMENDED** - one stop shopping	

Name of Report/ Author/Year	Target Group	Methodology # of Participants	Themes/Needs/Recommendations Consumer Perspective	Themes/Needs/Recommendations Provider/Other Perspective
Report on Needs Survey of Senior Citizens in Ancaster & Glanbrook July, 1990	senior citizens (65+) in Ancaster, Jerseyville, Mt. Hope and Binbrook	- in-home administered questionnaires Ancaster n = 140 Jerseyville n = 41 Mt. Hope n = 31 Binbrook n = 46	*- 4% to 15% expressed that income not adequate (concerns expressed about GST and taxes) - 20% reported feeling lonely at times with 8% saying this is a major problem - need for snow shovelling, transportation, heavy housework help, grass cutting and small repairs - need for transportation - need seniors' apartments - need to make seniors aware of social and government services	

Name of Report/ Author/Year	Target Group	Methodology # of Participants	Themes/Needs/Recommendations Consumer Perspective	Themes/Needs/Recommendations Provider/Other Perspective
Report on Needs Survey of Senior Citizens in Stoney Creek June 1990	seniors (over 65) in rural and under served areas in Stoney Creek	- 235 in home administered interviews - community meeting	Most important problem facing seniors: inflation/fixed income loneliness transportation/low mobility health loss of independence lack of seniors' housing adequate housing that is in good repair and has good safety standards livable and affordable housing is of primary importance for the well-being of older people. We need to make the connection between housing and health 5% indicated that income was not adequate to cover expenses and 17% said that income 'barely' covered expenses 25% of sample said that inflation and fixed income were the most important problems facing seniors today; need more secure finances 20% reported feeling isolated; 3% felt this was a serious problem identified the need for the following services: heavy housework, snow shovelling, house cleaning, yard work and small repairs transportation; especially for those 75+ need more seniors residences also need to have better communication about what services are needed recommended more clubs and activities	

Name of Report/ Author/Year	Target Group	Methodology # of Participants	Themes/Needs/Recommendations Consumer Perspective	Themes/Needs/Recommendations Provider/Other Perspective
A Mental Health Plan for Hamilton-Wentworth HWDHC June, 1992	those with mental illness, particularly those with serious or prolonged mental illness	focus groups n = 171 resource inventory questionnaire n = 125 community planning workshops n = 200 participants included consumers, family members/caregivers and service providers	1 empowerment 2 housing 3 meaningful activity (including work, education, living skills, income) 4 advocacy/information 5 treatment 6 social/recreational 7 support to families 8 crisis support 9 transportation	**SERVICE PROVIDERS** 1 treatment 2 crisis support 3 housing 4 consumer empowerment 5 meaningful activity 6 support to families 7 advocacy/information 8 social recreation **FAMILY/CAREGIVERS** 1 treatment/crisis support 2 support to families/housing 3 meaningful activity 4 social/recreational 5 empowerment

Name of Report/ Author/Year	Target Group	Methodology # of Participants	Themes/Needs/Recommendations Consumer Perspective	Themes/Needs/Recommendations Provider/Other Perspective
Program Review of the Emergency Night Time Drop-In Program Wesley Urban Ministries by S & S Research June, 1994	homeless people this is a program evaluation typical user profile = white, heterosexual 25-55 year old men who are english speaking; on GWA, FBA; many with disabilities	**questionnaires** n = 73 current users n = 33 potential users n = 8 staff n = 19 community service providers	**BARRIERS TO SERVICE** - late opening hour - winter only policy - language, culture and safety concerns - harassment, safety issues for women **NEED** - statement of rights - better outreach to all potential users - more nutritious food - improved cleanliness - 24 hour drop-in for homeless people	

Name of Report/ Author/Year	Target Group	Methodology # of Participants	Themes/Needs/Recommendations Consumer Perspective	Themes/Needs/Recommendations Provider/Other Perspective
Wesley Urban Ministries Community Health Centre Proposal October 1994	homeless and underhoused <u>women</u> in the urban core homeless and underhoused <u>youth</u> in the urban core homeless and underhoused <u>men</u> in the urban core low income culturally diverse families and seniors	**CONSUMER QUESTIONNAIRES** a n = 35 adults n = 11 youth n = 21 at Victoria Park n = 71 at Kirkendall b key informant interviews n = 36	most of the needs identified related specifically to traditional medical needs **n = 35 (Wesley adults)** problems with vision, eyes, oral health, foot health, effects of drug and alcohol use, smoking, physical abuse, etc. **n = 11 (Wesley youth)** emotional health, problems with eyes, back, spine, STD's, sexual abuse, etc. **n = 71 (Kirkendall adults)** problems accessing family doctor, problems with chronic medical problems, language problems **n = 21 (Victoria Park)** problems with transportation, child care, access to physicians	**BARRIERS TO SERVICE** - communication/language skills - lack of self-esteem - lack of knowledge - lack of transportation - intimidation **NEEDS** - mental health - physical, sexual abuse - behavioural change; health promotion programs

Name of Report/ Author/Year	Target Group	Methodology # of Participants	Themes/Needs/Recommendations Consumer Perspective	Themes/Needs/Recommendations Provider/Other Perspective
A Community Based Needs Assessment of Settlement & Integration Services in Hamilton-Wentworth April, 1992	diverse immigrant communities (diverse culturally, racially and linguistically)	questionnaires mainstream service providers n = 26 members of diverse communities n = 46 individual interviews n = 10 focus groups with immigrant communities n = 90 focus groups with service providers n = 17	**the caveat:** there is 'diversity within diversity' 1 need general orientation to life in Hamilton (government programs, the city, adaption to local practices) 2 need cultural interpreters 3 need for ESL classes (waiting lists and day care a problem) 4 employment - recognition of skills 5 housing - affordable and safe, long waiting lists 6 immigration matters 7 need for community contact - contact with people of same culture 8 information on investment and commercial ventures BARRIERS - lack of information about service availability - considerable language and interpretation problems - insensitivity to cultural and racial differences by agency staff - lack of recognition of skills To Address Barriers: - ethno specific organizations or a central resource centre for immigrants (less interest in a central resource centre)	1 need for consolidation of settlement services (ie basic necessities) into one centre with satellite offices 2 need for cross-cultural training/education for service providers 3 need to address specific issues of mental health 4 need to ask clients what they need 5 ESL classes 6 education 7 employment 8 health 9 advocacy/integration 10 assistance with information 11 settlement GAPS - language differences - racial/cultural sensitivity - how services are organized - lack of awareness of services

Name of Report/ Author/Year	Target Group	Methodology # of Participants	Findings	
Determinants of Health in Hamilton-Wentworth: A Comparative Analysis of Hamilton-Wentworth With Other Regional Municipalities by Mike Pennock, Rosemary Foulds October, 1994	residents of Hamilton-Wentworth	comparative analysis of our Region with 9 other regional municipalities using some indicators as they relate to the determinants of health	- higher unemployment rate among men, youth and women - highest rate of poverty in one parent families - second highest poverty rate among low income families, children on FBA and school drop-outs - high rates of children in care - high levels of air pollution - low levels of education - few people in "high control" positions in workplaces	

Name of Report/ Author/Year	Target Group	Methodology # of Participants	Themes/Needs/Recommendations Consumer Perspective	Themes/Needs/Recommendations Provider/Other Perspective
Chairman's Task Force on Sustainable Development Summary report # 2: Community Focus Groups June, 1991	recent immigrants mentally challenged residents of s second level lodging homes native people single mothers women victims of sexual assault/dome stic violence women of Elizabeth Fry group home families involved with John Howard society rural seniors users of food banks unemployed youth	focus groups n = ?	- need to address issue of poverty - need to address negative societal attitudes - need for increased sense of safety - need for better policing - need for better justice system - need for enhanced education both formal, informal and personal - enhanced social service delivery - enhanced access to culture/recreation - improved health care system - increased "civility" among people - improved public amenities - development of "complete" neighbourhoods - improved housing (choices, affordability, etc.) - Improvements in the economy and employment - improved transportation/urban movement system - preservation of rural society/lifestyle -- better environment	

Name of Report/ Author/Year	Target Group	Methodology # of Participants	Themes/Needs/Recommendations Consumer Perspective	Themes/Needs/Recommendations Provider/Other Perspective
Social Safety Net: Voice of Concern by THIAC December, 1994 "This report is a response to proposed social security reform	residents from Hamilton-Wentworth	1. Focus groups 2 individual interviews 3 surveys n = 125	1. Working/employment adequate training, income, work-sharing possibilities, job security, improved UIC system, provisions for working parents learning lifelong learning, literacy, student centred learning, access to co-ops, apprenticeships, access to secondary school system security (social security network) remove disincentives to work, address family and child poverty, subsidized day-care, reform the Canada Assistance Plan, provide adequate incomes, do not encourage workfare, affordable, adequate housing, progressive taxation, eliminate free trade, include singles in policy planning, achieve full employment, develop prevention programs	

Name of Report/ Author/Year	Target Group	Methodology # of Participants	Themes/Needs/Recommendations Consumer Perspective	Themes/Needs/Recommendations Provider/Other Perspective
Health and Social Service Priority Planning Process for 1994 by the Health and Social Services Committee of the Region of Hamilton - Wentworth	- a priority setting process for the Health and Social Services Committee	- To develop priorities there was a review of Vision 2020, The Premier's Council on Health, Well Being and Social Justice and the views of the people from six community agenies: Association of Agenies for Treatment and Development, the Hamilton-Wentworth District Health Council, The Hamilton Foundation, Social Planning and Research Council, The United Way and The Ministry of Community and Social Services		- basic needs/income/employment - social support - healthy beginnings - healthy schools - healthy workplaces - environment

Name of Report Author/Year	Target Group	Methodology/#of Participants	Themes/Needs recommendations Consumer Perspective	Themes/Needs/ Recommendations Provider/Other Perspective
Report on the 1993 Community Consultation on Priorities for Demonstration and Development for Hamilton-Wentworth by the United Way (priority setting document)		Survey through a discussion paper and a questionnaire to a range of social service, church, labour, education and government organizations n=192 people		- Poverty among children and young adults - unemployment - family violence - hunger - issues facing diverse communities - elder/family abuse

Name of Report / Author / Year	Target Group	Methodology / # of Participants	Themes / Needs / Recommendations Consumer Perspective	Themes / Needs Recommendations Provider Perspective
Community Consultation on Human Service Priorities, April 1995	1) Community Service Providers 2) donors 3) users of community services examined four issues 1) needs and priorities 2) modes of intervention 3) system structure 4) accountability	- community workshops for service providers donors and consumers, phone ins, and written comments	**Consumers** - employment - adequate income - upgrading/retraining and education for workers - affordable housing - income support programs - empowerment oriented services for the disabled - community and family support - better integrated services - increased awareness and responsiveness by politicians, funders, administrators and consumers - services for children - cross cultural programs - family education / support - medical services **Donor Perspective** - adequate food - clothing - shelter - prevention programs - increased awareness of resources - developing community identity - using existing resources more efficiently	**Priority Needs** - priorities need to be seen from a holistic perspective with acknowledgement of community values - food - adequate housing - freedom from violence **Other Priorities** - supportive social networks - skills for life - learning/education - adequate income - employment - marketing skills - parenting skills - freedom from discrimination - access to all aspects of society and information - healthy environment - self-esteem /self worth - support during crises - physical/mental health - spirituality - leisure/recreation - literacy - nutrition - prevention strategies

10 George Street, Suite 301, Hamilton, Ontario L8P 1C8
10 rue George, bureau 301, Hamilton (Ontario) L8P 1C8

TEL: (905) 570-1441
FAX: (905) 570-1202